EXHIBIT A

To: lossnotlcemwia <lossnoticemwia@unitedfiregroup.com>, United Fire Group WebMaster <Webmaster@unitedfiregroup.com>

From: United Fire Group WebMaster < Webmaster@unitedfiregroup.com>

Date: Tue, 24 May 2011 16:39:14 -0500 Subject: New Auto Loss Report for SD

The attached claim was submitted via the internet for, PLUCKER DEBBIE, to United Fire Group. The confirmation number for this notice is 26106.

(If there is no attachment on this email, please contact Web Help at 1-800-895-6253.)

IRFILENO:90625038 Userdata1:230299 Server:www.unitedfiregroup.com Claim #: 4001032727

KKH

Printed: 05-25-2011

UNITED FIRE & CASUALTY COMPANY NOTICE OF NEW CLAIM ASSIGNMENT

Email SWADEGUNITEDFIREGROUP.COM

SHERRI WADE PO BOX 73909

CEDAR RAPIDS IA 52407-3909 Bus Phone 319-399-5758

Claim No: 4001032727 Loss Date: 05-24-2011

Pol Period: 03-30-2011 to 09-30-2011 Policy No: 90625038 COB: 0110

Reinsurance-ACL: NO

Superv: SNIFFIN ROBERTA

Ext

0

Subro Supv:

RST: Subro Rep:

_____AGENT_______AGENT______AGENT____AGENT____ 230299 BRENNER & JUSTICE INS INC

JUDY BRENNER

Phone 605-362-8200 Fax 605-362-9366

DEBBIE PLUCKER

Oth 605-728-5595 O

000-000-0000 0 000-000-0000

45730 SD HIGHWAY 44 PARKER SD 570535624

DVPLUCKER@AOL.COM Email

Email2 SSN/FEIN

Contact:

45730 SD HIGHWAY 44

Oth 605-728-5595

0 000-000-0000 0 000-000-0000

SD 57053 PARKER

Email: DVPLUCKER@AOL.COM

When:

Where: Claim Type: Auto PIP/MEDICAL/INCOME CLAIM ONLY Est

Location of Occurrence

Time 11:00AM Cat No

I-29 N AT (MRM 071-63 + .108

HARRISBURG SD 57032

Authorities SDHP

Violations UNKNOWN

Report #:

Loss Description

INSURED.

Coverage File: N A SEMI TRACTOR/TRAILER RIG LOST BOTH REAR TANDEMS WHICH HIT THE SEMI THAT WASIN FRONT OF THE INSURED AND THEN BOUNCED OFF THAT TRUCK AND HIT OUR

Claim #: 4001032727

KKH

F 14 165

Printed: 05-25-2011

Insured Driver DEBBIE PLUCKER A/M Ind. A

Oth 605-728-5595

000-000-0000 SSN

DOB:

Adjuster-2

Sex F

45730 SD HIGHWAY 44

PARKER SD 57053

Emaill DVPLUCKER@AOL.COM

Email2

Type DRIVING License St SD Lic# 00588887

Date Hire

Relation POLICYHOLDER #1

Fault UNDETERMINED

Freeform Rel. INSURED

Used w/Permis. Yes

Purpose PERSONAL

Clt No. 001

DEBBIE PLUCKER

45730 SD HIGHWAY 44

PARKER SD 570535624

Ext Oth 605-728-5595

0 0

RISK 014

2011 CHEVROLET SILVERADO C

1GCRCSE07BZ331885

SSN 000000000 Sex Age 51

Where Damage can be Viewed

What Doing Injury

Where Taken

Remarks

Reserve Type Adjuster-1

TLS SI

Cover LC AU MР ΑÜ

1,250.00 F 1,250.00 F

WADE SHERRI WADE SHERRI

2____________ ** ** R E M A R K S * * R E M A R K S * * R E M A R K S ** **

ASSIGNMENT TRANSMITTAL

Loss notice statews that insured is going to try to collect for her damages from the other carrier. If you don't need the collision line, I can close it

INSURED HAS FILED CLAIM WITH DAKOTALAND, INC. FOR HER VEHICLE. (THE LOCAT ION OF THE ACCIDENT IS CORRECT MILE MARKER # BUT THE CITY PROBABLY IS NOT. YOUR SYSTEM REQUIRED ME TO PUT ONE IN BUT THERE ISN'T ONE ON THE HP REPO RT AND THEY WEREN'T AT A CITY).

Report Date Reported By Insured 05-24-2011 Reported Name

Phone: 000-000-0000 Ext

Claim #: 4001032727

KKH

Printed: 05-25-2011

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PP0311 0698 UND	ERINSURED MOTORISTS COVERAGE	

PP0165	1010	SD - AMENDMENT OF POLICY PROVISIONS
PP0311	0698	UNDERINSURED MOTORISTS COVERAGE
PP1301	1299	DAMAGE TO YOUR AUTO EXCLUSION
PP7023	0209	ROADASSIST 24/7
ST1393	0701	IMPORTANT PRIVACY NOTICE
811492	1003	NOTICE FAIR CREDIT REPORTING ACT
ST1623	0707	NOTICE - IDENTITY RECOVERY
ST1644	0109	POLICY WEBSITE STUFFER

1/30/2012 3:26:19 PM - RSNIFFIN-Roberta Sniffin
CLMS - 4001032727
Reviewed on diary
I presented to the insured, Debbie Plucker an alternative to signing the med auth as outlined in my August 3rd letter. If she wishes to have us use her med pay she can just pick up her medical bills at Lanpher Chiro and forward to us directly.
Thus, far she has eschewed this option.
Roberta
1/4/2012 10:28:54 AM - SWADE-Sherri Wade
CLMS - 4001032727
I spoke with the adverse carrier, he said he thought he had an agreement with the insd but then she said she was going to contact an atty and he hasn't heard from her since.
12/12/2011 2:19:31 PM - RSNIFFIN-Roberta Sniffin
CLMS - 4001032727
Reviewed on diary
Looks like Debbie will be settling w/ adverse and getting her bills paid there— Okay by us—

11/16/2011 2:22:45 PM - SWADE-Sherri Wade CLMS - 4001032727 I spoke with Derron with the other carrier, he has not concluded this with the insd and still hopes to do so shortly & pay all of the meds directly. He said he will call me once it's done. 11/15/2011 9:07:07 AM - SWADE-Sherri Wade CLMS - 4001032727 Noted & agreed. I have this on diary until January to make sure the other carrier paid the same. 11/14/2011 2:20:28 PM - RSNIFFIN-Roberta Sniffin CLMS - 4001032727 Reviewed file on diary Sherri Really, we do not have ORM here because the insured refused to sign a med auth. However, unless adverse pays her bills; Medicare will present subro to us. So I do not see that we can close until we have received same.	Roberta
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Food for thought.		
Thanks		
Roberta	83	
Nobel ta		
9/28/2011 3:19:28 PM - RSNIFFIN-Roberta Sniffin	191	
CLMS - 4001032727		
Reviewed on diary		
RES		
9/27/2011 3:13:09 PM - SWADE-Sherri Wade	s .	
CLMS - 4001032727		
Clmt carrier called and it sounds like they will be settling with the insd directly in the new will leave the file open until any settlement is confirmed.	ct few weeks. I	
9/27/2011 2:26:40 PM - SWADE-Sherri Wade		

CLMS - 4001032727	
Returned a call to adv carrier and advised we have	ave not made any payments on behalf of the insd.
	ä
	==
9/2/2011 10:53:57 AM - SWADE-Sherri Wade	
CLMS - 4001032727	
Noted	
8/31/2011 12:32:47 PM - RSNIFFIN-Roberta Sn	lffin
CLMS - 4001032727	
Sherri-	
File on diary	
	e Debbie either sends her bills into us w/ the records or
we wait for subro from Medicare and pay acco	raingly.
I've discussed w/ agent and said we need coop	paration from Dahbia
The discussed wy agent and said we need coop	eration from Depuble.
The agent advised that Debbie prefers that you	u do not call her again so if you have to call for anything~
send file to me and I will help.	and hot can not again so if you have to can to, anything
8	
	l out of Debbie's refusal to help us help her We have a
QR in the works and she said she was canceling	g us anyway.

Ţhanks
Roberta
8/10/2011 3:46:45 PM - RSNIFFIN-Roberta Sniffin
CLMS - 4001032727
Received a call from Mary at Dr. Lancer's office—Debbie told her about the Med Auth problem. Mary said to Debbie that she cannot just mail us the medical records because of HPPA but that she will talk to the Dr. about just giving Debbie a copy.
I advised Mary that the Med Auth Debbie signed for us will not fly as all crossed out etc. Mary said she tried to explain the procedure to Debbie, but she will not just sign a Med Auth.
Again, Mary will see if Dr. Lancer will just let Debbie have her own records to give us.
Roberta
8/4/2011 10:31:07 AM - SWADE-Sherri Wade
CLMS - 4001032727
Returned a call to Derrin at Liberty Mutual at 877-884-1799 ext 3845. His claim AB3961-070925. Advised I have not paid out MP yet & expect to do so and will update him when I have made any payments.

a sess Mana se sa

8/3/2011 10:06:22 AM - SWADE-Sherri Wade
CLMS - 4001032727
Noted
<u> </u>
8/3/2011 9:56:45 AM - RSNIFFIN-Roberta Sniffin
CLMS - 4001032727
While I was typing that letter Debbie called—I advised her of exactly what I put in the letter. She will obtain records next week as well as a billing log and mail into us.
Roberta
8/3/2011 9:56:04 AM - RSNIFFIN-Roberta Sniffin
CLMS - 4001032727
Sherri
I have mailed a letter to Debbie Plucker and e-mailed a copy to her agent, Kathy Justice. No need to leave her messages anymore because she will not answer them as she is angry about us not just paying her bills.

I've offered her an alternative to the Medical Authorization which is to obtain her medical reports

herself and send into us. Please advise if you receive because we want to make sure they are complete. Also, if Medicare is paying I've let her know, we must set aside same.
RES
7/29/2011 10:35:09 AM - RSNIFFIN-Roberta Snlffin
CLMS - 4001032727
Called Debbie Plucker as I advised the agent I would do same to discuss the Med Auth and if she does not want to sign, some alternatives.
Left a call back message
Roberta
7/26/2011 1:44:30 PM - SWADE-Sherri Wade
CLMS - 4001032727
Roberta:
Yes I have already spoken with Liberty Mutual and they have adequate limits. They have also accepted liability.
I sent a QR.

Thanks!
Sherri
7/25/2011 3:46:31 PM - RSNIFFIN-Roberta Sniffin
CLMS - 4001032727
Sherri
\bar{y}_{i}
Because adverse vehicle is a truck, I would assume that they have liability limits equal too or greater than ours so UIM would be ruled out—on diary just make a call to Liberty Mutual to make sure if you have not done same yet.
Should we QR this insured? What do you think?
Thanks
Roberta
7/22/2011: 11:31:23 AM - SWADE-Sherri Wade
CLMS - 4001032727

I left the insd a message to call be she returned a med auth & blacked half of it out. I'm not sure what is going on with the insd. She is being illusive now and uncooperative.
I spoke with the agt Kathy & she said she'd make a call to insd.
7/13/2011 10:32:12 AM - SWADE-Sherri Wade
CLMS - 4001032727
I left the insd another message today and also sent her a letter outlining her obligations with the policy. We are almost 2 months since the loss and no meds auths but receiving bills.
7/5/2011 3:46:37 PM - SWADE-Sherrl Wade
CLMS - 4001032727
I left the insd a message to get add'l info so we can complete the forms required by medicare that were received today.
6/30/2011 2:14:53 PM - SWADE-Sherri Wade
CLMS - 4001032727
left the Insd a message to f/u on med auths
E N

6/14/2011 9:56:49 AM - SWADE-Sherri Wade

CLMS - 4001032727

I spoke with the insd. She is filling out the med auths today. She said she is having some post traumatic stress associated with seeing the wheel fly across the highway. She said she is having some trouble with her fear of driving now. She hopes it will go away and has not tx for this. She said her neck & shoulder still bother her, especially when she is sleeping. She is tx 1/per week b/c the DC is 90 miles round trip. We discussed the concerns that arise when the stop wasn't forceful enough to tighten her seat belt and weeks later she is still sore. She said maybe she forgot & her seat belt did tighten.

6/6/2011 11:04:34 AM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Completing diary early as received CAP report

Claimant vehicle has accepted fault, we have subrogatable MP -- Insured disabled and collects Medicare. Need to watch treatment closely.

Roberta

6/6/2011 11:02:20 AM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Sherri--

File looks good as does the claimant screen. Watch saying yes to ORM until we get the Medical Authorization. While I like that you are on top of it, until they sign the Med Auth it is not official. This one is ready to go already though so I would not change a thing.

Roberta
8 III
6/6/2011 10:57:33 AM - SWADE-Sherri Wade
CLMS - 4001032727
I called the insd. She said she's been having some trouble getting her mall and does not remember seeing our med auths. I printed the ones I sent her previously and mailed them again.
5/26/2011 1:28:39 PM - SWADE-Sherri Wade
CLMS - 4001032727
Derron from Liberty Mutual said they will not let their insd give us a statement but they have accepted liability. Apparently his insd does all the work on their own trucks. His address is PO Box 168328, Irving, TX 75016.
5/26/2011 11:14:53 AM - KHARRIS-Kiley Harris
CLMS - 4001032727
so noted have sent for police report and asked for narrative
a
5/26/2011 11:12:45 AM - SWADE-Sherri Wade

CLMS - 4001032727
The other carrier is Liberty Mutual, adj: Derron Lax, Claim: AB961-070925, phone: 877-884-1977.
5/26/2011 11:10:46 AM - SWADE-Sherri Wade
CLMS - 4001032727
I left message for the other driver and the other carrier to call.
5/26/2011 11:06:22 AM - SWADE-Sherrl Wade
CLMS - 4001032727
Kiley:
Will you please order a copy of the PR and maybe we can get a copy with some kind of narrative?
Thanks a bunch!
Sherri

UNITED FIRE GROUP MEDICARE QUARTERLY RESPONSE RECORD RESPONSE DATE 02/08/2012

CLAIM 4001032727 CLAIMANT OOL

SUBMITTED

RETURNED

ACTION

DELETE

HICN

SSN

LAST NAME

PLUCKER

PLUCKER

FIRST NAME

DEBBIE

DEBBIE

MIDDLE INIT

F

L

GENDER

F

DOB

POLICY #

011090625038

MSP EFFECT DT

05/24/2011

MSP TERM DT

TYPE IND

D - NO FAULT

DISPOSITION CD

O1 RECORD ACCEPTED WITH ORM

APPLIED ERROR CODE

APPLIED COMPLIANCE FLAG(S)

Reviewed slg 02/09/2012 09:39

UNITED FIRE GROUP

Report to: Supervisor Roberta Sniffin

Claim No.

4001032727

Insured: Adjuster; Debbie Plunker S Wade

Transcriber:

Date: 1/4/12

Dictated Date:

Adjuster Initials:

slg

Supervisor initials and Date through Image Right:

FILE	STATUS	SUPDATE	

ENCLOSURES

res 01/04/2012

1) Medicare update

FILE STATUS/UPDATE

The other carrier had hoped to have this resolved with the insd by now and I confirmed today that a resolution has not been met. The insd is aware we are here and does not want to speak to us. I suggest we diary this file out another 6 months so if the insd decides to use MP, we are ready and perhaps by then she will have resolved with the other company.

RESERVES

Verified in ACS today? ⊠Yes ☐No

Reserves Adequate? ⊠Yes ☐No

Reserve amounts, analysis and recommendations:

Insd Debbie Plunker:

MP: \$1,250 reserved, \$5k limit

NEXT REPORT DUE/FURTHER ACTION NEEDED

A 6 month diary will put us to 7/6/12. Thank you.

UNITED FIRE GROUP MEDICARE QUARTERLY RESPONSE RECORD RESPONSE DATE 11/09/2011

CLAIM 4001032727 CLAIMANT 001

SUBMITTED

RETURNED

ACTION

DELETE

HICN

SSN

LAST NAME

PLUCKER

PLUCKER

FIRST NAME

DEBBIE

DEBBIE

MIDDLE INIT

107

Ŧ

DOB

POLICY #

GENDER

011090625038

MSP EFFECT DT

05/24/2011

MSP TERM DT

TYPE IND

D - NO FAULT

DISPOSITION CD

O1 RECORD ACCEPTED WITH ORM

APPLIED COMPLIANCE FLAG(S)

Reviewed slg 11/14/2011 16:20

UNITED FIRE GROUP

Report to: Supervisor Roberta Sniffin

Ciaim No.

4001032727 **Debbie Plunker**

Insured: Adjuster:

S Wade

Transcriber:

Date: 10/5/11

Dictated Date:

Adjuster Initials:

slg

Supervisor Initials and Date through Image Right:

FILE STATUS UPDATE	

ENCLOSURES

Your correspondence with the insd & agt res 10/05/2011 1)

2) Medicare response

FILE STATUS/UPDATE

The insd has still not responded to us. The Clmt carrier called on 9/27/11 and it sounds like they will be settling with the insd directly in the next few weeks. I will leave the file open until any settlement is confirmed.

RESERVES

Verified in ACS today? ⊠Yes ☐No

Reserves Adequate? ⊠Yes □No

Reserve amounts, analysis and recommendations:

Clmt 1 Debbie Plucker:

MP: \$1,250 reserved/\$5k limit

NEXT REPORT DUE/FURTHER ACTION NEEDED

90 days to 1/6/12. Thank you.

UNITED FIRE GROUP MEDICARE QUARTERLY RESPONSE RECORD RESPONSE DATE 08/10/2011

4001032727 CLAIM CLAIMANT 001

SUBMITTED

RETURNED

ACTION

ADD

HICN

SSN

LAST NAME

PLUCKER

PLUCKER

FIRST NAME

DEBBIE

DEBBIE

MIDDLE INIT

 \mathbf{F}

F

DOB

GENDER

POLICY #

011090625038

MSP EFFECT DT

05/24/2011

MSP TERM DT

TYPE IND

D - NO FAULT

DISPOSITION CD

Ol RECORD ACCEPTED WITH ORM

APPLIED COMPLIANCE FLAG(S)

Reviewed slg 08/12/2011 09:41

To: JUSTICE KATHRYN E; From: RSNIFFIN Cc: Bcc:
Subject: Plucker
Date/Time Sent: 8/3/2011 9:58 AM
BEGINNING OF MESSAGE
Drawer: CLMS FileNo: 4001032727
Kathy
Just as soon as I finished my letter and e-mailed to you Debbie called I advised her of the information in the letter and she will obtain her medical records and mail into us.
Thanks
Roberta
END OF MESSAGE
Attached Files:
IR110000.pdf

To: JUSTICE KATHRYN E; From: RSNIFFIN Cc: Bcc: Subject: Plucker claim Date/Time Sent: 8/3/2011 9:50 AM
BEGINNING OF MESSAGE
Drawer: CLMS FileNo: 4001032727
Kathy
I was unable to reach Debbie by telephone so I am sending her this letter advising that if she can provide the Medical records from her DC, Lanpher Chiro we can review for payment. I also wanted her to understand if Medicare paid anything, we have to pay them back.
If she contacts you with questions, please direct her to me and I can help.
Thanks!
Roberta E. Sniffin, CPCU United Fire Group Claim Supervisor
END OF MESSAGE
Attached Files: IR110000.pdf

August 3, 2011

Debbie Plucker 45730 SD Hwy 44 Parker, SD 57053-5624

Claim: 4001032727

Dear Ms. Plucker:

Thank you for forwarding your signed medical authorization. Unfortunately, it will not be accepted by any medical facility with all of the changes made to the document.

If you do not wish to complete a medical authorization, then I can present another solution which is to obtain your medical records from Lanpher Chiropractic Office and forward to us. We will then review same for payment. Please do note that with Medicare's Involvement if they have paid any monies, we must set aside that amount of your Medical Payments coverage to pay them back.

If you have any questions, feel free to contact me at 1-800-343-9131, ext. 5430.

Sincerely,

Roberta E. Sniffin, CPCU United Fire Group Claim Supervisor UNITED FIRE GROUP

Report to: Supervisor Roberta Sniffin

Claim No.

4001032727 Debbie Plunker

insured: Adjuster:

S Wade

Transcriber:

Date: 8/3/11

Dictated Date:

Adjuster Initials: slg

Supervisor Initials and Date through Image Right:

FILE STATUS UPDATE

ENCLOSURES

1) Medicare Forms res 08/03/2011

- 2) Medical Auth from Insd
- 3) Letter to insd
- 4) QR

FILE STATUS/UPDATE

As you know, we've been attempting to assist the insd with her MP claim. We are having a difficult time helping her because she is not returning our calls. Insd returned the medical authorization but edited it to the point that we will not be able to use it. She also has not returned the Medicare forms and she is a Medicare recipient.

I tried calling her again today and got her voice mail. Instead of leaving a message, I have sent her a letter. Insd was initially friendly and cooperative and I do not understand her change in behavior. I will continue to try to reach her but at this point the agent has become involved, you & I have left messages and now I have written to her. In my letter of 7/13/11 I outlined her duties to cooperate.

We have received \$876 in DC bills thus far that are unpaid.

RESERVES

Verified in ACS today? ⊠Yes □No

Reserves Adequate? XYes No

Reserve amounts, analysis and recommendations:

Debbie Plucker:

MP: \$1,250 reserved/\$5k llmit

NEXT REPORT DUE/FURTHER ACTION NEEDED

60 days to 10/6/11. Thank you.

CD2115 (3/10/2008)

Did not mail since insd called in - slg 8/3/11

August 3, 2011

Debbie Plunker 45730 SD Highway 44 Parker, SD 57053

RE:

Claim: 4001032727 Loss Date: 5/24/11

Dear Ms. Plunker,

I have been trying to reach you and have not been able to connect with you. I would like to assist you with your claim and need to speak with you. Will you please call me when you receive this letter? I can be reached Monday through Friday from 8:00am until 4:30pm at 800-343-9131 ext 5758.

Thank you! Sincerely,

Sherri Wade, Claims Representative

To: Diefendorf, Tom; Haines, Michele; From: KHARRIS Cc: Bcc:	10#00
Subject: QR FOR YOUR REVIEW Date/Time Sent: 7/26/2011 2:21 PM	
BEGINNING OF MESSAGE	
Drawer: CLMS FileNo: 4001032727	
END OF MESSAGE	
Attached Files: IR110000.tif	

United Fire and Casualty Company RISK ANALYSIS

CLAIM NO .:	4001032727
	Debbie Plucker
DOL:	5/24/11

or come tongs

COMMERCIAL LINES: ☐ OR PERSONAL LINES: ☒ AGENCY: Brenner & Justice POLICY NO.: 90625038

Check applicable blocks and explain in remarks section.

Criedle apprication victural arr	w entrems str t dissures adoptions	
Physical impairment Insured uncooperative Poor area or adjoining hazards at location Loss frequency Umusual hazard (Explain) Premises or operations inconsistent w/policy description Drinking, drugs or gross negligence involved Change of address, occupation or marital status Photos in claim file VEHICLE Vehicle in poor condition or with special equipment Vehicle not listed on policy Vehicle on policy not owned by insured Change of business classification or territory Extra hazards (Explain) Liability claim reserve/payment \$ Business use or drives over 10 miles to work Ummarried operator under 30 Driver over 70 Traffic citation disposition OWI/drug related conviction No drivers license or license revoked Driver not listed on policy Previous accidents or losses (Explain) Improper PIP/UM rejection Improper vehicle classification or usage Miscellaneous reasons (Explain) Photos in claim file Name of Driver Date of Birth Relationship of Driver to Insured	Late notice of claim Previous losses - date and type Insured's attitude - lack of cooperation (Explain) Under insured/over insured property value is \$ Insurance to value: Actual Cash Value Replacement Cost Secondary residence Mobile home construction Business conducted on residential premises (Explain) Condition and age of property (Explain) Defective or badly wom roof Composition overlay on wood shingles Wood or corn pellet burning stove Upkeep of premises - Inside and outside (Explain) Handrails needed (Explain) Walks, drives or parking area in unsafe condition (Explain) Dangerous animals - type and breed (Explain) Swimming pool, hot tub, Trampoline or horse(s) on premises (Explain) Unfenced swimming pool / hot tub Boat used commercially or in tournaments (Fishing Included) Vacant or unoccupied - Vacant Risk isolated or inaccessible (Explain) Structure Below Average for Area High crime area (Explain) Unusual occupancy or area (Explain) Unusual occupancy or area (Explain) Undesirable tenants Hazardous or unguarded machinery (Explain) Exposure hazards (Explain)	
W/C Injured under 18 or over 70 Unsafe operations - poor housekeeping Overall quality of employees low Operations out of home state or extra hazardous Photos in claim file Temparates Insafest accommodate of the consideration of the c	(Explain) Miscellaneous reasons (Explain) Photos in claim file EXPLANATIONS FOR UNDERWRITING DEPT. USE ONLY Date: Reviewed by: SENT TO U/W AND MARKETING 7-26-11 KKH	
Date: 7/26/11 Adjuster: S Wade		

United Fire and Casualty Company RISK ANALYSIS

CLAIM NO.	4001032727
INSURED:	Debbie Plucker
DOL:	5/24/11

COMMERCIAL LINES: ☐ OR PERSONAL LINES: ☒ AGENCY: Brenner & Justice POLICY NO.: 90625038

Check applicable blocks and explain in remarks section.

	AND THE RESIDENCE OF THE PARTY
GENERAL Physical impairment Insured uncooperative Poor area or adjoining hazards at location Loss frequency Umusual hazard (Explain) Premises or operations inconsistent w/policy description Drinking, drugs or gross negligence involved Change of address, occupation or marital status Photos in claim file VEHICLE Vehicle in poor condition or with special equipment Vehicle on policy not owned by insured Change of business classification or territory Extra hazards (Explain) Liability claim reserve/payment \$ Business use or drives over 10 miles to work Ummaried operator under 30 Driver over 70 Traffic citation disposition OWl/drug related conviction No drivers license or license revoked Driver not listed on policy Previous accidents or losses (Explain) Improper PPP/UM rejection Improper PPP/UM rejection Improper vehicle classification or usage Miscellaneous reasons (Explain) Photos in claim file Name of Driver Date of Birth Relationship of Driver to Insured W/C Injured under 18 or over 70 Unsafe operations - poor housekeeping Overall quality of employees low Operations out of home state or extra hazardous Photos in claim file REMARKS Claim is © Open Closed Payments to date \$0 Will immediate cancellation prejudice claims handling? No Date: 7/26/11 Adjuster: S Wade	PD/IM/GL Lete notice of claim Previous losses - date and type Insured's attitude - lack of cooperation (Explain) Under insured/over insured property value is \$ Insurance to value: Actual Cash Value Replacement Cost Secondary residence Mobile home construction Business conducted on residential premises (Explain) Condition and age of property (Explain) Defective or badly worn roof Composition overlay on wood shingles Wood or corn pellet buning stove Upkeep of premises - Inside and outside (Explain) Handrails needed (Explain) Walks, drives or parking area in unsafe condition (Explain) Dangerous animals - type and breed (Explain) Swimming pool, hot tub, Trampoline or horse(s) on premises (Explain) Unfenced swimming pool / hot tub Boat used commercially or in tournaments (Fishing Included) Vacant or unoccupied - Vacant Risk isolated or inaccessible (Explain) Structure Below Average for Area High crime area (Explain) Unusual occupancy or area (Explain) Unusual occupancy or area (Explain) Exposure hazards (Explain) Unsafe labor conditions (Explain) Risk incorrectly classified (Change in operations?) (Explain) Miscellaneous reasons (Explain) Photos in claim file EXPLANATIONS FOR UNDERWRITING DEPT. USE ONLY

To: JUSTICE KATHRYN E;
From: SWADE
Cc:
Bcc:
Subject: Debbie Plucker Claim
Date/Time Sent: 7/22/2011 11:32 AM

BEGINNING OF MESSAGE

Drawer: CLMS
FileNo: 4001032727

END OF MESSAGE

Attached Files: IR110000.pdf

UNITED FIRE GROUP MEDICARE MONTHLY RESPONSE RECORD RESPONSE DATE 06/09/2011

F

CLAIM 4001032727

CLAIMANT 001

HICN

SUBMITTED RETURNED

LAST NAME PLUCKE PLUCKE

FIRST INITIAL D

202

F

SSN

RRE DCN1 201105314001032727001 201105314001032727001

RRE DCN2

GENDER

DISPOSITION CD O1 ID'D AS A MEDICARE BENEFICIARY

HICH UPDATED IN ACS

Reviewed slg 06/09/2011 10:42

UNITED FIRE GROUP

Report to: Supervisor Roberta Sniffin

6 70 6 70 10

Clalm No. Insured: Adjuster: 4001032727 Debbie Plucker Sherri Wade

Transcriber: Edith McBurney

Date: 06-01-11

Dictated Date: Adjuster Initials: 05-26-11

res 06/06/2011

Supervisor Initials and Date through Image Right:

AUTO CAP REPORT

CONTACT DATE

05-25-11: Spoke with our insured and obtained her statement.

05-26-11: Left message for claimant to call.

05-26-11: Spoke with claimant carrier.

ENCLOSURES

- 1. Accident report from DOT.
- 2. Insured RS.
- 3. Blank Medical Authorization to insured.
- 4. Sub notice CC

COVERAGE

This loss was submitted under the insured's Personal Auto Policy PP0001 (06-98). Our insured has Medical Payments benefits subject to a \$5,000 llmit. Our insured also has Collision Coverage subject to a \$500 deductible. However, currently, she is going through the other carrier for her vehicle. The policy period is 3/30/11 through 9/30/11.

DATE-TIME-PLACE

Date: 5/24/11 Time: 11:00 a.m.

Place: I-29 near Harrisburg, SD

DRIVER(S)

The insured driver is our named insured.

The other driver is Fred Finch who resides at 3712 North 7th Avenue, Sioux Falls, SD 57104. His phone number is 605-338-0870.

PASSENGER(S)

Insured Vehicle

None

Claimant Vehicle

None

FACTS

Our insured was northbound in the inside lane on I-35 traveling at approximately 65 mph. There was a semi also traveling northbound in the right lane at the time of the loss. The other party was southbound on I-29, and as they came near to the insured vehicle, the rear double tires came off the semi trailer, bounced across the highway, hit the semi that was to the right of the insured, bounced back and hit the front of the insured vehicle. Our insured had slammed on her brakes to try to avoid the loss, but could not turn to the right or the left due to the semis on both sides of her.

Our insured said that following the loss she did not feel like she was immediately injured, but a few hours later she started to have pain in her neck and shoulder.

<u>WITNESSES</u>

None known.

POLICE REPORT

We have a copy of the accident report in the file, and I have ordered another copy hoping to get a full narrative.

INJURED PERSON(S) BI-MP-UM-UIM

Our named insured states she has some pain in her neck and shoulder. She suffers from several diseases and illnesses that may affect her recovery. Her SSN is and DOB She receives Medicare benefits because she has been disabled since 1991. I have notified Medicare of this loss.

INDEX REPORT

CD2114A (3/10/2008)

PROPERTY DAMAGE

Unknown

COLLISION

Unknown

SALVAGE

None

LEGAL LIABILITY - Duty Owed, Duty Breached, Damages and Proximate Cause

The other party had a duty to have safe equipment on his semi. Because the company services and owns the semi, they are liable for this accident for unsafe equipment.

The insured has a statute of limitations of 5/24/14. She also has Medical Payments benefits for these three years.

CONTRIBUTION

None

SUBROGATION

We will subrogate against Liberty Mutual, and I have made contact with their adjuster. According to the adjuster, they have accepted liability and will not allow their insured to give us a statement.

FURTHER INVESTIGATION

Review police report when it comes in.

DEMANDS, OFFERS, SETTLEMENTS, FUTURE HANDLING

I sent the insured all of the forms to complete for her medical claim and will process these when they are returned.

ADVERSE CARRIER'S LIABILITY LIMITS

Unknown

RESERVE	RECOMMEI	NDATIC	SNC
---------	----------	--------	-----

Verified in ACS today? ⊠Yes ☐No Reserves Adequate? ☑Yes ☐No

Reserve amounts, analysis and recommendations:

Claimant #1Debbi Plucker: MP: \$1,250 reserved, \$5,000 limit. Reserves are good.

PICTURES

No

RISK ANALYSIS FORM NECESSARY?

No

AGENT ADVISED

Yes

NEXT REPORT DUE

60 days to 8/6/11

OTHER COMMENTS

UNITED FIRE & CASUALTY COMPANY PO BOX 73909 CEDAR RAPIDS, IA 52407-3909 FAX 800-863-1703 PHONE 800-343-9131

MAY 25 2011

230299 BRENNER & JUSTICE INS INC 3701 W 49TH ST, STE 201 SIOUX FALLS, SD 57106

RE:Claim Number: 4001032727 Insured: PLUCKER DEBBIE
Ins. Driver: DEBBIE PLUCKER
Policy National Conference of the Property of the Property

Commence of the No.

Policy Number: 90625038
Date of Loss: 05-24-2011
Loss Location: I-29 N AT (MRM 071-63 + .108 HARRISBURG SD

Claimant: DEBBIE PLUCKER

We acknowledge receipt of the notice of loss for the above captioned claim. The adjuster assigned to this claim is:

> SHERRI WADE PO BOX 73909 CEDAR RAPIDS, IA 52407

Phone No: 319-399-5758 Branch Fax: 800-863-1703

The adjuster will make every effort to contact the insured and/or claimant promptly. Please direct any inquiries regarding this claim to the adjuster.

If you are unable to contact the adjuster and need immediate assistance please call the office as shown on this letterhead.

Sincerely,

UNITED FIRE & CASUALTY COMPANY Claims Department

To: BRENNER JUDY MAE; From: KHARRIS Cc: Bcc: Subject: agent update for your file Date/Time Sent: 2/21/2012 12:44 PM	(8)
BEGINNING OF MESSAGE	
Drawer: CLMS FileNo: 4001032727	
END OF MESSAGE	
Attached Files: IR110000.tif	



emailed 2-21-12 kkh

United Fire & Casualty Company United Life insurance Company Addison Insurance Company Lafayette Insurance Company United Fire & Indemnity Company United Fire Lloyds Texas General Indemnity Company

FEBRUARY 21 2012

23-0299 **BRENNER & JUSTICE INS INC** Email Delivery judy.brenner@midconetwork.com

CLAIM STATUS REPORT

Re:

Claim No.:

4001032727

Insured:

PLUCKER DEBBIE

Date of Loss:

05/24/2011

Policy No.:

110 90625038

Reserves & Payments:

Total Payments Made To Date:	\$ 0.00
Remaining (Outstanding) Reserves:	\$ 1,250.00
Total Incurred:	\$ 1,259.50

Accident/Injury Description: A tire came off the clmt vehicle, bounced across the highway, hit another vehicle and came back to hit the insd vehicle.

Current Status: The Insd has not submitted her med auth so I have not been able to assist her. It appears that she is going to settle with the other carrier directly but since that hasn't happened yet I leave the file open on a precautionary basis. I am going to follow-up with the other carrier in July and will update you at the same time as well.

If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE CLAIMS REPRESENTATIVE TO

CONFIDENTIALITY NOTICE: The information on this page contains confidential information belonging to the Sender and which are legally privileged. The information is intended only for the use of the individual or entity named above. If you are not the infended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action regarding any of the contents of this information is strictly prohibited. If you have received in error, please immediately notify the Sender at the below WATS number. Our office will relimburse you for the costs of receiving the documents and returning them to us. Thank you.



United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lloyds
Texas General Indemnity Company

FEBRUARY 21 2012

23-0299
BRENNER & JUSTICE INS INC
Email Delivery judy.brenner@midconetwork.com

......

CLAIM STATUS REPORT

Re:

Claim No.:

4001032727

Insured:

PLUCKER DEBBIE

Date of Loss:

05/24/2011

Policy No.:

110 90625038

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If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE CLAIMS REPRESENTATIVE TO

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To: BRENNER JUDY MAE;
From: KHARRIS
Cc:
Bcc:
Subject: agent update for your file
Date/Time Sent: 11/16/2011 3:00 PM

BEGINNING OF MESSAGE

Drawer: CLMS
FileNo: 4001032727

END OF MESSAGE

Attached Files: IR110000.tif



United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lioyds
Texas General Indemnity Company

NOVEMBER 16 2011

300 000 000

emailed 11-16-11

23-0299
BRENNER & JUSTICE INS INC
Email Delivery Judy.brenner@mldconetwork.com

CLAIM STATUS REPORT

Re:

Claim No.:

4001032727

Insured:

PLUCKER DEBBIE

Date of Loss:

05/24/2011

Policy No.:

110 90625038

Reserves & Payments:

Total Payments Made To Date:	\$ 0.00
Remaining (Outstanding) Reserves:	\$ 1,250.00
Total Incurred:	\$ 1,259,50

<u>Accident/Injury Description</u>: A tire came off the clmt vehicle, bounced across the highway, hit another vehicle and then hit the insd vehicle.

<u>Current Status</u>: The insd has not ever sent her medical authorization to us so we have not handled her medical claim yet. As I understand it, the other carrier intends to pay these meds directly to the provider but I am leaving my file open until this is done. If the insd decides to return the med auth, she can go through us yet.

If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE CLAIMS REPRESENTATIVE TC

CONFIDENTIALITY NOTICE: The information is intended only for the use of the information belonging to the Sender and which are legally privileged. The information is intended only for the use of the information is present the information information is present the information information is present the information information information is present the information information information is present the information information



United Fire & Casualty Company United Life Insurance Company Addison Insurance Company Lafayette Insurance Company United Fire & Indemnity Company United Fire Lloyds Texas General Indemnity Company

and the second second second

NOVEMBER 16 2011

23-0299 **BRENNER & JUSTICE INS INC** Email Delivery Judy.brenner@midconetwork.com

CLAIM STATUS REPORT

Re:

Claim No.:

4001032727

Insured:

PLUCKER DEBBIE

Date of Loss:

05/24/2011

Policy No.:

110 90625038

Reserves & Payments:

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If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE CLAIMS REPRESENTATIVE TO

CONFIDENTIALITY NOTICE: The information on this page centains confidential information belonging to the Sender and which are legally privileged. The information is intended only for the use of the Individual or antity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action regarding any of the contents of this information is strictly prohibited. If you have received in error, please immediately notify the Sender at the below WATS number. Our office will reimburse you for the costs of receiving the documents and returning them to us. Thank you.

From: KHARRIS Cc: Bcc: Subject: agent update for your file Date/Time Sent: 8/24/2011 10:16 AM
BEGINNING OF MESSAGE
Drawer: CLMS FileNo: 4001032727
END OF MESSAGE
Attached Files: IR110000.tif



emailed 8-24-11 kkh

United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lloyds
Texas General Indemnity Company

AUGUST 24 2011

23-0299
BRENNER & JUSTICE INS INC
Email Delivery judy.brenner@midconetwork.com

CLAIM STATUS REPORT

Re:

Claim No.:

4001032727

Insured:

PLUCKER DEBBIE

Date of Loss:

05/24/2011

Policy No.:

110

90625038

Reserves & Payments:

Total Payments Made To Date:	\$ 0.00
Remaining (Outstanding) Reserves:	\$ 1,250.00
Total incurred:	\$ 1,259.50

<u>Accident/Injury Description</u>: A semi tire came off a semi in the opposing lane, crossed in front of the lnsd vehicle, bounced off the semi next to her and struck her vehicle.

<u>Current Status</u>: As you know the insd does not want to return the medical authorization so we have been unable to process her claim. Hopefully the insd will return this form soon.

If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE
CLAIMS REPRESENTATIVE TC

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United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lloyds
Texas General Indemnity Company

AUGUST 24 2011

23-0299
BRENNER & JUSTICE INS INC
Email Delivery judy.brenner@midconetwork.com

CLAIM STATUS REPORT

Re:

Claim No.:

4001032727

Insured:

PLUCKER DEBBIE

Date of Loss:

05/24/2011

Policy No.:

110

90625038

Reserves & Payments:

Total Payments Made To Date:	\$ 0.00
Remaining (Outstanding) Reserves:	\$ 1,250.00
Total Incurred:	\$ 1,259,50

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If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE CLAIMS REPRESENTATIVE TO

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5/26/2011 11:11:09 AM - SWADE-Sherri Wade CLMS - 4001032727 I left message for the other driver and the other carrier to call.

5/25/2011 4:22:28 PM - SWADE-Sherri Wade CLMS - 4001032727 I obtained the insd's stmt.

5/25/2011 2:19:01 PM - SWADE-Sherri Wade CLMS - 4001032727 I left the insd a message to call.

O5-25-2011 08:09:49 SCHEDL4 - Scheduler 4 CLMS - 4001032727

Claim Representative assigned to loss.

UNITED FIRE & CASUALTY COMPANY PO BOX 73909 CEDAR RAPIDS, IA 52407-3909 FAX 800-863-1703 PHONE 800-343-9131

MAY 25 2011

230299 BRENNER & JUSTICE INS INC 3701 W 49TH ST, STE 201 SIOUX FALLS, SD 57106

RE:Claim Number:

4001032727

Insured:

PLUCKER DEBBIE

Ins. Driver:

DEBBIE PLUCKER

Policy Number: 90625038 Date of Loss:

05-24-2011

Loss Location: I-29 N AT (MRM 071-63 + .108 HARRISBURG SD

Claimant:

DEBBIE PLUCKER

We acknowledge receipt of the notice of loss for the above captioned claim. The adjuster assigned to this claim is:

> SHERRI WADE PO BOX 73909 CEDAR RAPIDS, IA 52407

Phone No: 319-399-5758 Branch Fax: 800-863-1703

The adjuster will make every effort to contact the insured and/or claimant promptly. Please direct any inquiries regarding this claim to the adjuster.

If you are unable to contact the adjuster and need immediate assistance please call the office as shown on this letterhead.

Sincerely,

UNITED FIRE & CASUALTY COMPANY Claims Department







July 1, 2011

2037 1 MB 0.390 ***AUTO**MIXED AADC 720 R:2037 T:12 P:15 PC:5 F:8301 UNITED FIRE GROUP PO BOX 73909 CEDAR RAPIDS, IA 52407-3909

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Reviewed slg 07/05/2011 15:46

SUBJECT:

Medicare Secondary Payer Rights and Responsibilities

Beneficiary Name: PLUCKER, DEBBIE L

Medicare Number:

Case Identification Number: 201117409001096 Insurer Claim Number: NOT AVAILABLE Insurer Policy Number: 4001032727 Date of Incident: May 24, 2011

Dear UNITED FIRE GROUP:

Please note that if we know that you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not at the end of this letter indicating that he/she is receiving a copy, please contact us immediately. If you have any questions regarding this letter and are represented by an attorney or other individual in this matter, you may wish to talk to your representative before contacting us.

We understand that you have made a claim against other insurance or workers' compensation. This letter is to let you know:

- What your responsibilities are as a Medicare beneficiary in connection with your claim;
- What information we need if you have a representative;
- What information we are requesting regarding your claim:
- What additional information you may receive on claims Medicare paid on your behalf on or after your date of incident;
- What information we need if there is a settlement, judgment, award or other payment for your claim (or if your claim is dismissed or otherwise abandoned).
- How to contact us (the MSPRC).



Medicare Secondary Payer Recovery Contractor PO BOX 138832 OKLAHOMA CITY, OK 73113 SGLICBNGHP Page 1 of 7







Your Responsibilities as a Medicare Beneficiary

- When no-fault insurance, liability insurance or workers' compensation is available to you, it must pay before Medicare pays. Some examples of no-fault and liability insurance include automobile or homeowners' medical payments coverage or personal injury protection, automobile liability or no-fault insurance, liability insurance which pays you because another individual or entity is negligent, malpractice insurance, etc.'
- Medicare makes "conditional" payments while your insurance or workers' compensation claim is pending to ensure that you receive the medical services you need in a timely manner.
- Once you receive a settlement, judgment, award or other payment for your insurance or workers' compensation claim, Medicare will determine if it has a recovery claim which must be repaid to the Medicare program. If Medicare determines that it has a recovery claim, you will be provided with a demand letter, which will include applicable appeal and waiver of recovery rights. Medicare will not take any collection action during the pendency of any appeal or waiver request. (The applicable law can be found at 42 U.S.C. 1395y(b)(2)(A) & (B).)

Information We Need If You Have a Representative

If someone is acting as your representative (that is, an attorney or other individual who is acting on your behalf), you should have the following information sent to us so we can communicate directly with your representative as well as with you.

- If your representative is an attorney, he/she should send us a copy of the agreement you signed when you retained the attorney. The agreement should also be signed or countersigned and dated by the attorney; be on the attorney's letterhead (or have a cover letter from the attorney); and have your name and Medicare Health Insurance Claim Number (the number on your Medicare card) at the top of the document. This will act as proof that this attorney is representing you, may act on your behalf, and receive your Medicare claims information directly from us.
- If someone other than an attorney is your representative, you must send a letter that is signed and dated, telling us that he/she is your representative and the date of the incident or injury for which he/she is acting as your representative. Please include your name and Medicare Health Insurance Claim Number at the top of the letter so that we can easily associate your agreement with your file. Your representative must also sign and date the letter to show that he/she has agreed to represent you. (Model language for proof of representation is available on our website at www.msprc.info.)

Land the man

As we stated at the beginning of this letter, if we have information that you have a representative, we are copying him/her on this letter. Your representative can take care of submitting this

Mudicare Secondary Payer Recovery Contractor PO BOX 138832 OKLAHOMA CITY, OK 73113

SOLICBNGHP Page 2-of 7







information to us. (However, if your representative's name is not shown at the end of this letter, please give a copy of this letter to your representative.)

Information Requested Regarding Your Insurance or Workers' Compensation Claim

We are requesting that your representative send us the name, address, and telephone number of the insurer or workers' compensation carrier involved and, if available, the policy number, claim number, and claim adjuster's name. (If you do not have a representative, we ask that you send us this information.)

If we have a name and address for the insurer or workers' compensation, we are copying them on this letter. However, we may not have more specific information, such as the claims adjuster you are working with, so we are requesting that you send us the complete information.

Information Regarding Claims Medicare Paid On Your Behalf on or After Your Date of Incident

Beneficiary representatives often ask us what "conditional" payments Medicare made on or after your date of incident. "Conditional" payments are those Medicare payments that are related to your pending insurance or workers' compensation claim.

Within sixty-five days from the date of this letter, you will receive a Conditional Payment Letter (CPL) which will show you the conditional payments Medicare has made on your behalf at that time, based upon the available information (an interim conditional payment amount). If you have an attorney or other representative, and we have appropriate proof of representation, we will also send a copy of this information to your representative. If we do not have the appropriate proof of representation, only you will receive the CPL; however upon receiving the appropriate proof of representation, a copy of the CPL will be forwarded to the authorized representative. (Please see the section above for information on appropriate proof of representation documentation.)

If your claim is for no-fault insurance or workers' compensation benefits, a copy of the CPL will be sent to the no-fault insurer or workers' compensation carrier if we have their information.

Please do not submit a request for a CPL because we will send one to you automatically as soon as the information is available. A separate request will not make the information available faster.

Once we send the CPL, we will also post this conditional payment information under the "MyMSP" tab of the www.mymedicare.gov website. The information at www.mymedicare.gov will be updated weekly with any newly processed claims. If you wish, you can also keep track of the medical expenses that were paid by Medicare, and if you have an attorney or other

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Medicare Secondary Payer Recovery Contractor PO BOX 138832 OKLAHOMA CITY, OK 73113

SGLICBNGHP Page 3 of 7







representative, provide him/her with this information. This may assist him/her with finalizing your settlement.

Information We Need If There Is a Settlement, Judgment, Award, or Other Payment (or If Your Claim Is Dismissed or Otherwise Abandoned)

Once you have a settlement, judgment, award, or other payment for your claim, if you have a representative, he/she should send us the following information. (If you do not have a representative, you will need to send us this information.)

- A copy of the settlement, judgment, award or other document regarding payment indicating the appropriate date and the total amount of the settlement, judgment; award or other payment.
 - · An itemized statement of attorney fees and other procurement costs that you are paying.

If settlement information is received by us prior to the CPL being issued to you, a Conditional Payment Notice (CPN) will be issued instead. The CPN gives you and/or your representative a specific timeframe to review and/or respond before the demand is issued.

If your claim has been dismissed or otherwise abandoned without a settlement, judgment, award, or other payment, please send us documentation of these actions so that we may close our record of this incident.

Mailing or Faxing Information to the MSPRC

Please use a copy of the enclosed "Correspondence Cover Sheet" whenever you or your representative submit any correspondence pertaining to the incident identified in the subject field of this letter. This cover sheet includes our address information and is pre-filled with information that will facilitate processing your correspondence. If you do not include a copy of this cover sheet, please include your name and your Medicare Health Insurance Claim Number (the number on your Medicare card) on all correspondence. This will allow us to associate the correspondence with the appropriate records.

Mcdicare Secondary Payer Recovery Contractor PO BOX 138832 OKLAHOMA CITY, OK 73113

SGLICBNGHP Page 4 of 7





Learn about your letter at www.msprc.info



Attached is a Privacy Act Statement that explains your privacy rights. You may be interested in the enclosed brochure about the MSPRC and the recovery process.

Sincerely,

ISPRC

MSP Recovery Contractor

Enclosures:

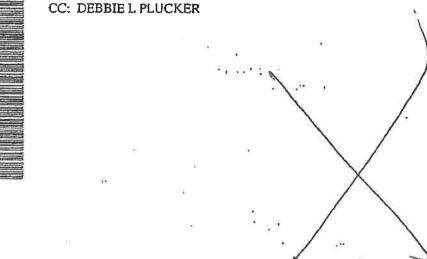
Privacy Statement

Medicare Secondary Payer Recovery Contractor Brochure

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Correspondence Cover Sheet





Medicare Secondary Payer Recovery Contractor PO BOX 138832 OKLAHOMA CITY, OK 73113

SGLICBNGHP Page 5 of 7

ISPRC



Learn about your letter at www.msprc.info



NOTICE TO BENEFICIARY ABOUT THE COLLECTION AND USE OF MEDICARE INFORMATION (PRIVACY ACT STATEMENT)

The Social Security Act mandates the collection of this information. The purpose of collecting this information is to properly pay medical insurance benefits to you or on your behalf.

Information collected may be given to health insurance providers and suppliers of services (and their authorized billing agents) directly or through fiscal intermediaries or carriers, for administration of Title XVIII; and to an individual or organization for a research evaluation, or epidemiological project related to the prevention of disease or disability, or the restoration or maintenance of health.

The identification number we are using is your Medicare Health Insurance Number. While furnishing the information on this form is voluntary, the Medicare program may not be able to make accurate claims payment when the requested information is not available in its records,

Public Law 100-503, the computer Matching and privacy Protection Act of 1988, permits the government to verify information by way of computer matches. Anyone who knowingly and willfullymakes, or causes to be made, a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment, or both.

According to the paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0214. The time required to complete this information collection is estimated to average 5 minutes per responder, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



ISPRC





Correspondence Cover Sheet

Beneficiary's Name:

PLUCKER, DEBBIE L

Medicare Number:

Date of Incident: May 24, 2011

Case Identification Number: 201117409001096

Insurer Policy Number:

4001032727

Insurer Claim Number:

NOT AVAILABLE

This cover sheet is for your use when mailing or faxing in correspondence to the MSPRC. Please retain a COPY of this cover sheet for any future correspondence. The information above will ensure accuracy when handling your case documentation.

Please indicate the type of correspondence you are submitting to the MSPRC to facilitate routing. Check all that apply:

Check	
Settlement information	
Retainer agreement or other authorization documentation	
Other	

<u>Note:</u> A Conditional Payment Letter is sent automatically within 65 days of this letter, or as soon as the information is available. Separate requests for initial Conditional Payment Amounts will not make Conditional Payment information available sooner.

In order to accurately associate claims to your case, please include a description of the injury. (i.e.: Knee, Physical Therapy, Slip and Fall, Lumbar Injury...)

Submit correspondence to the MSPRC address listed below:

Liability Insurance or No Fault Insurance Workers' Compensation:

Medicare Secondary Payer Recovery Contractor PO BOX 138832 OKLAHOMA CITY, OK 73113 1-405-869-3309







****FIRST CLASS MAIL- R:7510 T: P: F:53099 UNITED FIRE GROUP PO BOX 73309 CEDAR RAPIDS IA 52407-3909

June 27, 2011

DEAR UNITED FIRE GROUP:

RE: Beneficiary Name: DEBBIE L PLUCKER

HIC#:

Policyholder/Subscriber Name: Policy/Claim Number: 4001032727

Date of Illness/Injury:

Check Date: Check Number:

Check Amount: \$0.00

Medicare received a voluntary refund and/or information indicating that you have primary payment responsibility for medical services provided to the beneficiary noted above. The refund and/or information received contains insufficient information, therefore Medicare is unable to properly update its internal records and adjust any previously paid claims. A response is necessary within 10 days.

In order to accurately update our records, please call our toll free customer service line at: 1-800-999-1118 or 1-800-318-8782 for the hearing impaired or complete the enclosed questionnaire and return it in the enclosed courtesy reply envelope. Failure to respond timely could result in the incorrect payment of your medical claims.

Enclosure: Questionnaire

Continued

07/05/2011 08:52 AM

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE INFORMATION (PRIVACY ACT STATEMENT)

The Social Security Act mandates the collection of this information. The purpose of collecting this information is to properly pay medical insurance benefits to you or on your behalf.

Information collected may be given to health insurance providers and suppliers of services (and their authorized billing agents) directly or through fiscal intermediaries or carriers, for administration of title XVIII; and to an individual or organization for a research evaluation, or epidemiological project related to the prevention of disease or disability, or the restoration or maintenance of health.

The identification number we are using is your Medicare Health Insurance Number. While furnishing the information on this form is voluntary, the Medicare program may not be able to make accurate claims payment when the requested information is not available in its records.

Public Law 100-503, the Computer Matching and Privacy Protection Act of 1988 permits the government to verify information by way of computer matches. Anyone who knowingly and willfully makes or causes to be made a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment, or both,

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0214. The time required to complete this information collection is estimated to average 5 minutes per responder, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any suggestions for improving this form, please write to: CMS, Attn. PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

COMPLETED QUESTIONNAIRES SHOULD BE RETURNED TO THE BELOW ADDRESS, USING THE ENCLOSED ENVELOPE:

MEDICARE-COORDINATION OF BENEFITS CONTRACTOR MSP Claims Investigation Project PO BOX 33847 DETROIT, MI 48232-5847

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MEDICARE SECONDARY PAYER DEVELOPME	
DEBBIE L PLUCKER	CANCE CLADVI HONDER
INSTRUCTIONS: This form will be read by a computer. Please print as shown below. Use CAPITAL letters. Mark boxes with an X. USE BLACK OR EXAMPLE ABC 1 2 3	
SECTION A - INFORMATION ABOUT YOU 1) Do YOU have any group health plan coverage based upon your current employment? YES NO (If NO, go to SECTION B)	
2) How many employees, including yourself, work for the employer from whom you have Don't Know 1-19 20-99 100 or More (If less than 20,	health insurance?
Please provide information about the employer and the employer group health plan in the spaces be	
EMPLOYER NAME	
ADDRESS ADDRESS	
CTTY STATE ZIP	
NAME OF GROUP HEALTH PLAN	
ADDRESS	f 1 1 1 1 1
% ADDRESS	
CITY STATE ZIP	T T T T T
DATE INSURANCE COVERAGE BEGAN POLICY NUMBER	
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TYPE OF INSURANCE: HOSPITAL/MEDICAL HOSPITAL ONLY (I	DOCTOR/SUPPLIER)
3) Does your group health plan cover prescription drugs? YES NO (If NO, g Plense use your insurance card to provide the following information if available:	so to SECTION B)
- Rx GROUP	1111
MEMBER ID R.	K BIN
SECTION B - INFORMATION ABOUT YOUR SPOUSE/OTHER FAM	II V MEMPED
1) Do YOU have any group health plan coverage based upon your spouse's/other family	
employment? YES NO (if NO, go to SECTION C)	- 7°
2) How many employees, including your spouse/other family member, work for the employees have health insurance? Don't Know 1-19 20-99 100 or m (If less than 20, go to SI	ore
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	SECTION B-INFORMATION ABOUT YOUR SPOUSE/OTHER FAMILY MEMBER, CONTINUED							
	Policy Holder/Subscriber's First Name Policy Holder/Subscriber's Social Security Number							
	Policy Holder/Subscriber's Last Name							
	Please provide information about the employer and the employer group health plan in the spaces below: EMPLOYER NAME							
	ADDRESS							
	ADDRESS							
	CITY STATE ZIP NAME OF GROUP HEALTH PLAN							
	ADDRESS							
•	ADDRESS							
	CITY STATE ZIP							
	DATE INSURANCE COVERAGE BEGAN POLICY NUMBER							
	TYPE OF INSURANCE: HOSPITAL MEDICAL HOSPITAL ONLY MEDICAL ONLY (DOCTOR/SUPPLIER)							
	TYPE OF INSURANCE: HOSPITAL/MEDICAL HOSPITAL ONLY MEDICAL ONLY (DOCTOR/SUPPLIER) 3) Docs your family member/spouse's group health plan cover prescription drugs?							
	YES NO (If NO, STOP, go to SECTION C)							
	Please use your insurance card to provide the following information, if available:							
	Rx GROUP Rx PCN							
···	MEMBER ID Rx BIN							
	SECTION C-MORE INFORMATION ABOUT YOU							
	1) Are YOU receiving Black Lung Benefits? YES NO .							
	2) Are YOU receiving Workers' Compensation benefits? YES NO							
	3) Are YOU receiving treatment for an injury or illness which another party could be held liable or could be covered under no-fault or auto insurance? YES NO							
	If YOU answered YES to any questions in this section, go to SECTION D If YOU answered NO to all of these questions, sign below and return this form only.							
	Your Signature AREA CODE PHONE NUMBER							
	OMB#0938-0214 (CONTINUED ON NUMBOROSSE)							

43120	11 08:52 AW		
	MEDICARE SECONDARY PAYER DE	VELOPMENT.	CONTINUED
	NAME		NSURANCE CLAIM NUMBER
	DEBBIE L PLUCKER		478787267A
	SECTION D - MORE INFORMA	ATION ABOUT Y	OU .
	1) If YOU are getting Black Lung (Coal Miner's) Medical Be	nefits, print the date th	e benefits began.
	M M D D Y Y Y Y	· · · · · · · · · · · · · · · · · · ·	
	2) If YOU are now receiving any medical services related to a which YOU have or will file a Workers' Compensation cla		
	Please provide information about the employer and the employer, insur	ance carrier, and attorno	win the spaces below.
	EMPLOYER NAME		
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	SECTION D - MORE INFORMATION	ABOUT YOU, CONTINUED
	3) If YOU are now getting any treatment for an illness or injury please print the date of illness or injury:	ry for which another party could be held liable,
	NAME OF INSURANCE CARRIER	
	ADDRESS	
ı	ADDRESS .	
	CTY	STATE ZIP .
	POLICY or CLAIM NUMBER	
	NAME OF ATTORNEY (If Applicable)	
	ADDRESS	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	ADDRESS	
	CITY	STATE ZIP
14(0)	BRIEF DESCRIPTION OF ILLNESS OR INJURY	
	LI I I I I I I I I I I I I I I I I I I	+++++++++++++++++++++++++++++++++++++++
	4) If YOU are now getting any treatment for an illness or injur	Ti which could be covered under no fault or
¥	automobile insurance, print the date the of illness or injury NAME OF INSURANCE CARRIER	W. W. D. D. A.
•	ADDRESS .	
	ADDRESS	
	CITY	STATE ZIP
	POLICY or CĻAIM NUMBER	
	NAME OF ATTORNEY (If Applicable)	
	ADDRESS	
	ADDRESS	
	CITY	STATE ZIP
	BRIEF DESCRIPTION OF ILLNESS OR INJURY	
	Your Signature	AREA CODE PHONE NUMBER
		AREA CODE PRONE NOMBER
	OMB # 0938-0214	UF000060

May 26, 2011

Medicare Coordination of Benefits PO Box 33847 Detroit, MI 48232

RE: HIC#:

BENFICIARY: Debbie Plucker INCIDENT DATE: 5/24/11 INSURED: Debbie Plucker OUR CLAIM #: 4001032727

To whom it may concern:

Please accept this letter as your report of this incident:

BENEFICIARY ADDRESS: 45730 SD Highway 44, Parker, SD 57053

DOB:

TYPE OF INCIDENT: Motor Vehicle Accident LOCATION OF INCIDENT: I-29, Harrisburg, SD

INJURY: Soft tissue – neck & shoulder

EMPLOYER COVERAGE: N/A

ATTORNEY: N/A

BLACK LUNG: Unknown

WORK COMP: N/A

If you have any questions, please feel free to call us at 319-399-5758. Our normal office hours are Monday through Friday from 8:00am until 4:30pm.

Sincerely,

Sherri Wade, Claims Representative

To: New Claims <newclaims@unitedfiregroup.com>

From: "messaging@concordfax.com" <messaging@concordfax.com>

Date: Mon, 20 Jun 2011 07:25:09 -0500

Subject: New 3 pages fax message from 16786946000, LexisNexis

You have received a 3 pages fax at your fax number 18885149190.

The fax was received at 2011/06/20 07:23:23.

Thank you for using Concord Fax Online.

www.concordfax.com

Purpose of use: Personal Was vehicle used with permission? Yes Was driver injured? Injury description: PROPERTYDAMAGED **Property Description:** 1991 Freightliner (we didn't damage it- it damaged us) is property a vehicle? Yes Is property insured? Yes Other Carrier: ATJZ91453456051 Policy Number: Damage Description: don't know don't know Where can damage be seen? **Estimate Amount:** Owner: Dakotaland, Inc. Address: PO Box 84038 Sloux Falts, SD 57118 Phone: Driver: Frederick Flnch Address: 3712 N 7th Ave Sioux Falls, SD 57104 H: (605)338-0870 Phone: Plucker.pdf

*Reported By: Insured Previously Reported: NO

*Completed By: KATHRYN E JUSTICE - KATHY.JUSTICE@MIDCONETWORK.COM

Remarks: Insured has filed claim with Dakotaland, Inc. for her vehicle. (The location of the accident is correct mile marker # but the city probably is not. Your system required me to put one in but there isn't one on the HP report and they weren't at a city),

KHARRIS - A

4001032727

UNITED FIRE GROUP

Auto Loss Report

Policy Number: 90625038 Account Number: 237798

Loss Date: 05/24/2011 11:00 AM

Reference Number: 26106

Agency: - 230299

Reported Date: 05/24/2011

Completed Date: 05/24/2011 4:38 PM

PLUCKER DEBBIE *Name:

*Address: 45730 SD HIGHWAY 44 PARKER, SD 57053

dvplucker@aol.com Email:

*Phone: 0: (605)728-5595

Location Code: Marital Status: Married Birth Date:

Name:

Address: 46730 SD HIGHWAY 44

PARKER, SD 57053

Phone: O: (605)728-5595

Where to Contact: When to Contact:

Email: dvplucker@aol.com

*Location:

I-29 N at (MRM 071-63 + .108

Harrisburg, SD 57032

*Loss Type:

PIEMEDICAL INCOME CLAIM ONLY

Loss Time: 11:00 AM Report Number:

Authority Contacted:

Violations/Citations: Unknown

Description: A semi tractor/trailer rig lost both rear tandems which hit the semi that wasin front of the insured and then

bounced off that truck and hit our insured.

FINSUREDWELLERS FIRE BUILDING

Veh# Year Make

Model

Body VIN State Plate

2011 CHEVROLET

SILVERADO C1500 LT

1GCRCSE07BZ331885

Owner:

Same As Insured

Phone: Email:

Address:

Email:

Estimate Amount: Where can vehicle be seen? When can vehicle be seen?

Damage Description:

see next page

Other insurance:

UNSUREDIDRIVER

*Name: DEBBIE PLUCKER

Address: 45730 SD HIGHWAY 44

PARKER, SD 57053

dvplucker@aol.com

Phone: 0: (605)728-5596

Relation to Insured: Insured

Birthdate:

License Number: 00588887 License State: SD

LexisNexis 355571301

6/20/2011 8:23 AM PAGE 1/003 Fax Server



For Customer Support refer to the appropriate platform below:

OrderPoint 800-934-9698 Orderpoint.support@lexisnexis.com

Accurint for Insurance 866-277-8407 Accurint_support@lexisnexis.com

REPORT ATTACHE	Lexis.com Law Firm accounts 800-543-6862	
PAGE COUNT: 3		333 \$13 3332
ne:		
CLIENT: 3182 DIVISION: 0001 ADJUSTER: XCAE CLAIM: 40010	3P 32727(COLL)	
TRANSACTION#: DATE:	355571301 06/17/2011	
DATE OF LOSS: STREET: CITY: COUNTY: STATE:	05/24/2011 TIME OF LOSS 129 N HARRISBURG LINCOLN SD	d:
INVESTIGATING A REPORT NUMBER REPORT TYPE : PARTY 1 : PARTY 2 : PARTY 3 :		
CAR:	MAKE: YEAR: TAG;	
DRIVER LICENSE: ADDITIONAL INFO ALSO ASK FOR TH): E NARRATIVE ON THE POLICE	REPORT
POLICY #: POLICY STATE: LOSS KIND:		
NOTE:		
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Auto Accident

Page 1 of 1

Auto Accident Confirmation

Thank You for Your Order!

Order Date 12:13:55 EDT - Thursday May 26, 2011

Back to Order Form Order a Different Report Type Using the Current Data

Claim #: 4001032727(coll) Adjuster ID: XCAE3P Division Account: AAK 0001 Report Type: Auto Accident Loss Date: 05/24/2011 Time: Street: 129 N Cross Street: close to mile marker 71-63 City: Harrisburg State: sd Zip: County: LINCOLN 1st Party/Driver: Plucker Debble Driver License #: License State: Birth Date: SSN: VIN: 2nd Party Involved: Finch Frederick 3rd Party Involved: Vehicle Tag #: Tag State: Vehicle Year: Vehicle Make: Vehicle Model: Agency Name: South Dakota Highway Patrol Agency Type: HP Report #: Preclact

LexisNexis 8/20/2011 8:23 AM PAGE 2/003 Fax Server 355571301

Reviewed slg 06/20/2011 09:07

1106470 05/24/2011 11:00:00AM City - Rum NCK CJENSEN - South Dakote Highway Patrol	al LINCOLN County Photos not taken	
On I 29 N at (MRM 071,63 + .105) Road; I 29 N MRM: 0 Nearest crossing: 0.37 Miles N of 273 ST Intersection:	0.00 Non-junction	
Latitude: 49.497919 Longitude:	-95.798412	
FHE: Motor vehicle in transport FHE Loe: On roadway Road Cond: Dry Surface Type: Concrete Trafficway: Two-way, divided, unprotected (painted >4 foot) median Road Allignment: Straight and level	Manner of Collision: Angle Lighting: Daylight School bus related: No (school bus not involved)	
Workers present: No	Work zone locati Not applicable Work zone type: Not applicable	
Weather Clear		
Unit: 1 2011 CHEV SILVER DWINET: PLUCKER, DEBBIE LYNN 45730 SD HWY 44 PARKER, SD 570535824	Plate: 61GB20 Plate State: SD	
Init type: Motor vehicle in transport with driver sargo body: No cargo body IN: 1GCRCSE0782331885 Isineuver: Straight shead It and run: No	Occupants: 1 Veh config: Light truck (2 axles, 4 tires) Vehicle towed: No	
itial point of Impact: Front amage extent: Minor damage raffic device: No controls HE: Motor vehicle in transport amage Amt: \$2,000.00	Most damaged area: Front Underride/override; None - no underride or override Vision Contrib; None Veh Contrib; None Road Contrib: None	
aller: No trailer/ettachment avel Dir: Northbound surance: UNITED FIRE AND CASUALTY CO fective: 03/30/2011	Est Speed: 75 Driver statement Speed Limit: 75 Policy: 011080625038 Expiration: 09/30/2011	
vents Motor vehicle in transport		
nit: 2 1991 FRETTT	Plate: 68275C Plate State; SD	
wher: Dakotaland transing, PO Box 84038 SIOUX FALLS, SD 57118		
nit type: Motor vehicle in transport with driver argo body; Ven/enclosed box N: 1FUYDXYBOMP396183 aneuver: Straight ahead	Occupants: 1 Veh config: Tractor/semi-trailer	
rand run: No Itlal point of Impact: Rear mage extent: Functional damage effic device: No controls	Vehicle towed; No Most damaged gras: Regrunderride or override Underride/override; None - no underride or override Vielon Contrib; None	
HE: Motor vehicle in transport mage Amt: 5500.00 alier: Semi-trailer/double/triple avel Dir: Southbound	Veh Contrib: Tires Road Contrib: None Est Speed: 45 Onlyer statement Speed Limit: 75	
surance: LIBERTY MUTUALINS CO feetive: 01/01/2011	Polloy: AT./291453456051 Expiration: 01/01/2012	

LexisNexis

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3/003

Fax Server

Cerrier: 98 DAKOTALAND TRANSPORTATION INC PO BOX 84038 SIOUX FALLS SD 57118 Haz mat released: Not reported GVWR; 0 GCWR: Equipment failure (tires, Motor vehicle in transport brakes, etc.) Unit 1 PLUCKER, DERBIE LYNN Female 45730 SD HWY 44 No Injury Not transported PARKER SD 570535624 DL Chee: Car/truck/motorcycle DL Status: Normal, w/n *****8887 DL: SD (805) 728-5505 Phone: v restrictions Age: 61 DOB: 09/05/1 NO CITATIONS Airbag: Not deployed **Bection**: Not ejected Seating: Operator Sefety Equip: I ap belt and shoulder herness used No drug use No alcohol use Drug test refused Test not given Driver Contrib Nonmot Contrib None FINCH, FREDERICK ALBERT Mals 3712 N 7TH AVE No injury Not transported SIOUX FALLS SD 571040733 DL Class: DL Statue: Normal, win DL: SD ****7712 (805) 338-0370 Phone: restrictions Age: 71 DOB: Airbag: Not daployed Ejection: Not ejected Safety Equip: Lap belt and shoulder harness used Seating: Operator No drug use No alcohol use Drug test not given Test not given Driver Contrib Normal Contrib None Other FINCH, FREDERICK ALBERT 32-15-18 Droping, sifting, or leading load. Ф VEHICLE#2 WAS SOUTHBOUND ON 1-29 NEAR MP 71. VEHICLE#1 WAS NORTHBOUND ON 1-29 NEAR MP 71. THE TIRES ON THE REAR AXLE OF VEHICLE #25 TRAILER CAME OFF AND CROSSED THE MEDIAN. ONE OF THE TIRES CROSSED INTO THE NORTHBOUND LANE WHERE IT WAS RUN OVER BY A NORTHBOUND TRACTOR TRAILER. THE

TIRE WAS KICKED UP BY THE TRACTOR TRAILER THEN THE TIRE STRUCK VEHICLE #1. IT WAS LATER DISCOVERED

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	PLUCKER				CONTRACTOR STREET			1	5 (2 2) 2 (4 (5 (2 (5 (
	City		DEBBIE State	Zip Code	Date Of Birth		Number	(4)	7285595	State
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N		ast Name	Owner Fire		Street Add				Phon	e
l i	PLUCKER		DEBBIE		46730 SD HW	V AA				
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	FINCH		FREDERICK		3712 N 7TH A	VE		gni	3380870	
١	City			Zip Code	Date Of Birth	Driver License	Number	(4)	3360670	State
U	SIOUX FALLS		SD	671040733		00807712				SD SD
Ν	Vehicle Owner La	st Name	Owner Fin	st Name	Street Add				Phon	
1	INC		DAKOTALAN	ם	PO BOX 8403	8				
T	City	State	Zip Code	a Vehicle	Make	Vehicle Model	Vehi	ole Color	Ye	er
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Acc	oldent Records 605.	773,3868	SDHP SIO	ux Falls 60	05.367.5700 -	Aberdeen 605	.626.2286	- Rapid Cit	y 605.3	94.2286
(1)	SDCL 32-34-13 - "Repo	orts pursuant to	SDCL 32-34-7 to	o 32-34-12, incl	usive, and the infor	nation contained in suc	ch reports is not	privilaged and	may not be	
	held o	ionlidential. The	Stale of South	Dakola] shall c	otket four dallars fo	reach request to locate	a report on file		1111	
(2)	SDCL 32-34-7 - "The cone if comm	driver of any ma nousend dollers nunication, give	alor vehicle invol- or more to any c notice to the nea	ved in an acolde one person's pro one person's pro	ent resulting in bodil operty or two thouse aw enforcement offi	y injuries or death to a and dollars per acciden ser who has jurisdictor	ny person or pro 1 shall immedial 1,"	perly damage in	eng means o au abhare	int extent of lo
(3)	SDCL 32-12-81 - " Th such I	e (State of Sou Icensee and the	th Dakota] shell i e Ira/llo acoldenii	maintain racord in which the is	s or make suitable i canssa has been in	notations on the indviduous	nal report of ear	h licensee show	wing the co	lo anoitoivr
	18 U.S.C " A (BECTION 2721 to uny (#)	betson or entit	nt of motor vehic ly (2) highly	les, and any off personal inform	icer, employee, or onation without the	ontractor, thereof, sha express consent of th	l not knowingly e person to who	disclose or othe emotal dous m	rvise make tion applies	avallable
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June 6, 2011

Liberty Mutual Derron Lax PO Box 168328 Irving, TX 75016

RE:

Our Claim No.

4001032727

Our Insured:

Debbie Plucker

Date of Loss :

5/24/11

Location:

I-29, Harrisburg, SD

Your Policy/Claim No. AB961-070925

Your Insured:

Dakotaland Inc, Driver: Fred Finch

The above described accident caused damage(s) to property owned by our insured, or personal injuries, as evidenced by the enclosed bills or estimates. Our investigation of the accident discloses it was caused by the negligence of your insured. We have not completed settlement of this claim as of this date. Final settlement figures will be furnished at time of final payment.

In order to assist you in evaluating and processing the subrogation claim we are asserting, we may provide nonpublic personal information about our customer. We are sharing this information to effect, administer, or enforce a transaction authorized by the consumer. However, you are neither authorized nor permitted to: (1) use the customer information we provide for any purpose other than to evaluate and process the subrogation claim, or (2) disclose or share the customer information we provide for any purpose other than to evaluate and process the subrogation claim.

Thank you. UNITED FIRE AND CASUALTY COMPANY

Sherri Wade, Claims Representative Claims Department

319-399-5758

Enclosures

05/26/2011 01:01 PM

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Claim No. <u>400/03</u> 8	2727 RECORDED STATEMENT RESUME								
Interviewer: \(\interviewer \)	de								
Recorded on 5/0	25/11								
Recorded Statement of	Recorded Statement of Statement Deb Pucker								
Name:	Address: 57053 Phone No.: 728 5595								
DOB:	SSN:								
Medicare: (A)	HICN No.:								
SSDI: Disability	End Stage Ren: // ALS: //								
Injured: N/A	If yes, explain:								
2001 Silverado K 5/24/11 11AN Inspassing lare	heart disease Frigional, Conf. RESUME 1-29 NB by Since Falls passing ON - Wheel Bub tire across and web-light in middle	レ							
Waring Slat bel: CD1027B(10/14/2010)	J 1 75mpr J 1 UF000071	32							

2hrs afterwards - Stiffin in neck & right Shoulder Robin Lapher - Chiropractic Yald of pain fibrompligia: as needed not much feed back - appt next Tues Seni drier lane down walked down pselif OK - minimal Jame of axel both lane of tear of back of semi trailer S/W estimate on reh? Mintimo 3 Unknown Clain#

Derron Lax 877-884 1977 X 3845 Waim # AB 961-070925 Liberty Mictal

Recorded Date: 05-25-11

United Fire Group

Claim No.: 4001032727 Transcribed Date: 05-01-12 Recorded Statement Of: Debbie Plucker Page: 1 Q. This is Sherri Wade with United Fire Group, and I am interviewing Deb Plucker over the telephone on Wednesday, May 25th, of 2011 at approximately 2:30 p.m. This concerns an accident that happened on May 24th, 2011 near Harrisburg, South Dakota. Deb, I am with your insurance company, and Deb, would you please state your full name and spell out your last name? Debbie P-L-U-C-K-E-R. A. Q. And is this recording being made with your full knowledge and consent? Is this recording being made with your full knowledge and consent, Deb? A. I said yes. Q. Oh, sorry. A. That's okay. Q. What is your current home address? A, 45730 South Dakota Highway 44, Parker, South Dakota 57053. Q. And what's the best phone number to reach you at? A. 605-728-5595. And is that a home number, cell number? Q. A. It's a cell number. Q. Your date of birth? A. Date of birth, Q. And your social security number? A. Q. I'm sorry. Can you slow down a little bit, Deb. Can you tell me ? A. I though we were just being recorded. I didn't know you were documenting. A little bit of both. WE are being recorded, but I'm also documenting so I can. Q. A. Okay dokey. Q. Okay. Go ahead. What's your social security number again?

United Fire Group Claim No.: 4001032727

Recorded Statement Of: Debbie Plucker

Recorded Date: 05-25-11 Transcribed Date: 05-01-12

Page: 2

- A.
- And are you a United States citizen? Q.
- A. Yes, I am.
- Q. And do you qualify for any Medicare or Medicaid benefits?
- Yes, I do. A.
- O. And which of those do you qualify for?
- A. Medicare disability.
- Q, And how long have you been on disability?
- A. I believe since '91.
- Q. And what is that for?
- A. Um it's several different things put together, several different physical problems.
- Okay and can you describe that a little bit for me? Q.
- A Mm all the way from _ to musculoskeletal to heart disease to fibromyalgia to thyroid problems to bilateral calcaneal fractures to congenital deformations,
- Q. And is there one issue that has caused these problems for you?
- A. No, not altogether. They're just several different things.
- Q. Okay. And do you have a number that - that the disability benefits come under? Like I know with Medicare, they either get Part A or Part B so their member number is like the social security number plus an A or a B.
- A. Plus A.
- Plus A. Okay. And do you have any end stage renal disease? Q.
- A. No, I do not.
- Q. Lou Gehrig's?
- A. No, I do not.

United Fire Group Claim No.: 4001032727 Recorded Statement Of: Debbie Plucker Recorded Date: 05-25-11 Transcribed Date: 05-01-12 Page: 3

- Q. And what vehicle were you driving at the time of the accident?
- A. A 2011 Silverado.
- Q. And are you the registered owner of this vehicle?
- A. Yes, I am.
- Q. And I have the date of the accident as May 24th, 2011. Does that sound correct to you?
- A. Yes, it is.
- Q. And about what time of day did that happen?
- A. Uh the highway patrol states on his report it was 11:00 a.m.
- Q. And where were you at exactly?
- A. Um I-29 northbound south of Sioux Falls near the Harrisburg exit.
- Q. And what direction were you going?
- A. Northbound.
- Q. And how many lanes are there northbound on that highway?
- A. Other than the exit which is real close by, there are two ongoing lanes.
- Q. And were you in the inside or the outside lane?
- A. I was in the passing lane which would be the inside lane.
- Q. And in your own words can you tell me what happened?
- A. Um I was in the passing lane passing a semi tractor trailer. I was probably the front end of my vehicle was probably equivalent to being real close to the back end of his trailer, and as I was passing him, um a wheel, an entire wheel, hub tire, I mean the rim and the tire came sailing across from the west across the median down to the grass, full in front of me, hit the semi to my right that I was passing, hit the trailer and slammed into me as it deflected off of his trailer.
- Q. And what part of your vehicle was damaged?
- A. The front end.
- Q. And is it more towards the passenger side?

United Fire Group Claim No.: 4001032727

Recorded Statement Of: Debbie Plucker

Recorded Date: 05-25-11 Transcribed Date: 05-01-12

Page: 4

- A. No, it's actually almost right in the middle.
- Q. And what happened after that wheel hit your vehicle?
- A. Well, I automatically braked. I braked as hard as I could uh thinking I could let it go. I mean you try to think that it's gonna deflect off of the trailer and quickly get into the ditch, but I didn't have the time, and I was boxed in with the trailer being next to me on one side and the ditch being on the other. Uh I braked as hard as I could. All the belongings in my vehicle, my purse and everything, flew far forward and I fishtailed. I felt my vehicle fishtail as I was slamming on the brakes, and the patrol officer and I looked, and we could see where I braked for at least a good 30 feet.
- Q. And so you stayed in your lane then?
- A. Stayed in my lane, and I started to pull towards the ditch, but I obviously didn't want to go in the ditch.
- Q. And what's the speed limit in that area?
- A. I believe it's 75. I think I was going right around 65 miles an hour.
- Q. And did your airbags deploy?
- A. Did not.
- Q. And did you seatbelt tighten?
- A. Did not.
- Q. And were you wearing your seatbelt?
- A. Yes, I was.
- Q. And were you injured in the accident?
- A. I believe so. I didn't think so immediately, but about two hours afterwards I started to feel the stiffening in my neck and in my right shoulder, and I had such a terrible, terrible headache. It was just it was just progressive until this morning. I went to the doctor, and we're starting to treat now.
- Q. And what doctor did you go to?
- A. The name is Robin R-O-B-I-N Lanpher L-A-N-P-H-E-R.
- Q. And is that a chiropractor or medical doctor?

United Fire Group Claim No.: 4001032727

Recorded Statement Of: Debbie Plucker

Recorded Date: 05-25-11 Transcribed Date: 05-01-12 Page: 5

- A. _____ chiropractic.
- Q. And are is he right there in Parker?
- A. No, he's in Sioux Falls.
- Q. And do you normally see a chiropractor there?
- A. Yes, I do.
- Q. And what do you normally treat for?
- A. Just various little problems. I have fibromyalgia, so whenever it happens to be the problem at the time is what we treat.
- Q. So do you see him on a regular basis, or as an as needed basis?
- A. Needed it could be months, or it could be a couple times, and then I'm good for awhile.
- Q. Okay. And what did he tell you today when you went in?
- A. I think we just did an evaluation. I didn't get much feedback from him.
- Q. Did he give you some kind of treatment plan?
- A. I need to see him; not as far as a plan, um I do have an appointment next Tuesday in the afternoon.
- Q. And after the accident, did you speak with the semi driver that lost the wheel?
- A Yes, I did. He actually came down and because there was an ______ on each side of the road on the interstate right there, the Harrisburg exit, he approached up to the top of his exit going southbound, walked down and did come across the traffic lane onto the southbound lane just to I guess probably to see if I was okay.
- Q. And do you remember the extent of your conversation? Did he say anything about the wheel?
- A. No, it was just minimal. I mean everybody knows that you don't say a lot in a conversation like that ya know it's everybody is high strung, don't know what happened and ya know just basically just making sure that the other party was was gonna be all right.
- Q. And did the semi that you were initially passing, did that truck stop, or did it keep going?

United Fire Group Claim No.: 4001032727 Recorded Statement Of: Debbie Plucker Recorded Date: 05-25-11 Transcribed Date: 05-01-12 Page: 6

- A. It stopped, but the patrol officer let it go. It was, I believe, from Manitoba, Canada.
- Q. Okay. And the wheel that came off, did it come off of the axle, or was it like a spare wheel that was somewhere else on the truck?
- A. No, it came off of the axle and both of them were missing; one landed behind the tractor trailer going southbound and the west side of the ditch, and the other one came across the median.
- Q. And was it then the rear tires off of the semi trailer, or was it _____ trailer or on the semi?
- A. The rear two tires back there's tandems. There was the back set closest to the rear end of the trailer on the driver side.
- Q. And have you spoken with the other insurance company at all?
- A. I did this morning, yes.
- Q. And what did they tell ya?
- A. They told me uh they just got general information. They didn't really ask. They asked what happened basically told me the exact same thing that I'm telling you. Uh they wondered if I had an estimate on my vehicle. I said yes I had. It was already a preauthorized person that they deal with I guess on a constant basis, and I did let them know that I was going to see a doctor today.
- Q. Okay so they're gonna take care of the damages to your car?
- A. That is my understanding.
- Q. Okay. And do you know? Did the police issue any citations to anyone?
- A. I don't know. I don't know. That would be a good question to be answered for myself as well. I have no idea. None to me. I can state that, none to me.
- Q. Okay. All right. Are there any other facts about this, Deb, that I haven't asked you that you'd like to add for the statement?
- A. I don't think so other than I'm in a lot of pain, and it's too bad it had to happen, and I wish things would just be better.
- Q. Okay. Have you understood all of my questions?
- A. I think I have.

United Fire Group Claim No.: 4001032727 Recorded Statement Of: Debbie Plucker Recorded Date: 05-25-11 Transcribed Date: 05-01-12 Page: 7

- Q. Have all of your answers been true and correct to the best of your knowledge?
- A. Yes, they have.
- Q. And once again, did I have your full knowledge and consent in obtaining this recorded statement?
- A. Yes, you have.
- Q. Okay. I'm gonna go ahead and turn off this recorder then. It's now 2:42 p.m.
- A. Okay.

Transcribed by Edith McBurney on 05-01-12.

04/09/2012 12:42 PM

		3
[1500]	UNITED FI PO BOX 73	RE CASUALTY
HEALTH INSURANCE CLAIM FORM		909 IDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		
PICA		PICA TT
1. MEDICARE MEDICAID TRICARE CHAMPUS. (Medicare #) (Medicaid #) (Spansor's SN) (Member E.		1a, INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENTS BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PLUCKER DEBBIE L	FΧ	SAME
5. PATIENT'S ADDRESS (No., Street)	8. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
45730 SD HWY 44	Self X Spouse Child Other	SAME
PARKER SD	8. PATIENT STATUS Single Married Other	ZIP CODE TELEPHONE [Include Area Code) () 11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727 a. INSURED'S DATE OF BIRTH MM DO
ZIP CODE TELEPHONE (Include Area Code)	- Rule Trans-	ZIP CODE TELEPHONE (Include Area Oode)
57053-9998 ()	Employed Student Student	()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Inhial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727
A OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
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d. INSURANCE PLAN NAME OR PROGRAM NAME	10d, RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES X NO // yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I exhibite the	a SIGNING THIS FORM. release of any medical or other information necessary	13, INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either	to myself or to the party who eccepts essignment	earvices described below.
SIGNATURE ON FILE	DATE	SIGNATURE ON FILE
	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	The same of the sa
PREGNANCY(LMP)	GIVE FIRST DATE MM DD TY	FROM TO MM DD YY
17. NAME OF REPERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE	, NPI	FROM TO 20, OUTSIDE LAB? \$ CHARGES
05 25 2011		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Home 1, 2,	3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION
1. L 8470	<u> </u>	CODE ORIGINAL REF. NO.
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(1500)	UNITED FI PO BOX 73	IRE CASUALTY
HEALTH INSURANCE CLAIM FORM	CEDAR RAF	3909 PIDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		PICA TITA
1. MEDICARE MEDICAID TRICARE CHAMPUS	GROUP PLAN BLKULING OTHER	1e. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicald #) (Sponsor's SSN) (Member IC	(SSN or ID) (SSN) (SSN)	3
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	2. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Lust Name, First Name, Middle Initial)
PLUCKER DEBBIE L S, PATIENT'S ADDRESS (No., Susei)	6. PATIENT RELATIONSHIP TO INSURED	SAME 7. INSURED'S ADDRESS (No., Street)
45730 SD HWY 44	Self XSpouse Child Other	SAME
CITY STATE	8. PATIENT STATUS	CITY STATE
PARKER SD ZIP CODE TELEPHONE (Include Area Code)	Single Married Other	ZIP CODE TELEPHONE (Include Area Code)
57053 ()	Employed Student Student	()
S. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11, INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	FILE COLUMN IS AN ADVANCE OF	4001032727
E. OTHER MADRED & PODDY OR GROUP NUMBER	a EMPLOYMENTY (Current or Previous)	B. INSURED'S DATE OF BIRTH SEX
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
M F	Xes No SD	
4. EMPLOYER'S NAME OR SCHOOL NAME	o, OTHER ACCIDENT? YES XIO	O, INSURANCE PLAN NAME OF PROGRAM NAME
d, INSURANCE PLAN NAME OR PROGRAM NAME	10d, RESERVED FOR LOCAL USE	ZIP CODE TELÉPHONE (Include Area Code) 11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727 a. INSURED'S DATE OF BIRTH M DD M F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME UNITED FIRE AND CASUALTY d. IS THERE AND THERE AND CASUALTY
		YES XO # yes, return to and complete from 9 a-d.
READ BACK OF FORM BEFORE COMPLETING 12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I BURDAIZE the	3 & SIGNING THIS FORM. release of any medical or other information necessary	13, INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim, I also request payment of government benefits either below.	to myself or to the party who accepts assignment	services described below.
SIGNATURE ON FILE	DATE	SIGNATURE ON FILE
14. DATE OF CURRENT: (ILLNESS (First symptom) OR IS, INJURY (Accident) OR PREGNANCY(LMP)	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT LINABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
176	NPI	FROM TO MM DD YY
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1, L 8470	<u>+</u>	CODE ORIGINAL REF. NO.
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Kon in Faibher of	SYCAMORE AVE Ealls SD 571105737	506 N Sycamore Ave Sioux Falls SD 571105737
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NUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0969 FORM CMS 1500 (08/08

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HEALTH INSURANCE CLAIM FORM	, , , , , , ,	3909 PIDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		PICA TT
1. MEDICARE MEDICAID TRICARE CHAMPI	VA GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Program In Item 1)
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57053 ()	Employed Full-Time Part-Time	()
9, OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED:S POLICY GROUP OR FECA NUMBER
& OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	4001032727
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SEAN ALONG OUT AND A STORE COURS.		YES XO If yes, tetum to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLET! 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 subnotze th to process this claim, I also request payment of government benefits eith	e release of any medical or other information necessary 🗎	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I suttorize payment of insidical benefits to the undersigned physician or supplier for services described below.
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(I con this bill and are made a part in real.)	LANPHER DC	Lampher Chiropractic Office
Robin Lanpher DC Sign	N SYCAMORE AVE x Falls SD 571105737	506 N Sycamore Ave Sioux Falls SD 571105737
SIGNED DATE 8. 1407	834419	* 1407834419
NUCC Instruction Manual available at: www.nuco.org		APPROVED OMB-0938-0998 FOFM 60512500 (08/05)

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HEALTH INSURANCE CLAIM FORM	PO BOX 7:	3909 PIDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	CLOPIC (O)	
1. MEDICARE MEDICAID TRICARE CHAMPY	a coolin cool	PICA
1. MEDICARE MEDICAID TRICARE CHAMPUS (Medicard #) (Medicaid #) (Sportsor's SSN) (Member)	HEALTH PLAN BUKLUNG	1s. INSURED'S LO. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Lust Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PLUCKER DEBBIE L 5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	SAME 7. INSURED'S ADDRESS (No., Street)
45730 SD HWY 44	Self Spouse Child Other	SAME
CITY STATE	8, PATIENT STATUS	CITY STATE
PARKER SE ZIP CODE TELEPHONE (Indude Area Code)	Single Married Other	ZIP CODE TELEPHONE (Include Area Code)
57053	Employed Full-Time Part-Time Student Student	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INBURED'S POLICY GROUP OR FECA NUMBER
& OTHER INSURED'S POLICY OR GROUP NUMBER	s. EMPLOYMENT? (Current or Previous)	4001032727 • INSUREO'S DATE OF BIRTH SEX
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D. OTHER INSURED'S DATE OF BIRTH SEX	b, AUTO ACCIDENTY PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
C, EMPLOYER'S NAME OR SCHOOL NAME	OTHER ACCIDENT?	o. INSURANCE PLAN NAME OR PROGRAM NAME
	YE9 YO	UNITED FIRE AND CASUALTY
d Insurance Plan Name or Program Name	10d. RESERVED FOR LOCAL USE	V Clara Clara
READ BACK OF FORM BEFORE COMPLETIN 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: 1 BIZHOUS 11-6	g 4 Signing This Form.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize
to process this dain, I also request payment of government benefits either below.	te myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE	DATE	SIGNATURE ON FILE
14. DATE OF CURRENT) ILLNESS (First symptom) OR 16.	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	
05 24, 2011 PREGNANCY(LMP) 17. NAME OF REPERBING PROVIDER OR OTHER SOURCE 17.		FROM TO
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19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
05 25 2011 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Liens 1, 2	3 or 4 to ham Z4E by Line)	22. MEDICAID RESUBMISSION OBIGINAL REF. NO.
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(I Bodily that Indistration on the Association De ROB L	ANPHER DC	Lampher Chiropractic Office
KODIN Lanpher DC V	SYCAMORE AVE	506 N Sycamore Ave Sioux Ealls SD 571105737
SIGNED DATE 3. 14078	334419 ^a	* 1407834419
NUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FORM CM84-500 (08/05)

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[1500]	PO BOX 73	RE CASUALTY
HEALTH INSURANCE CLAIM FORM		1909 PIDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		
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1. MEDICARE MEDICAID TRICARE CHAMPY	HEALTH PLAN BLK LUNG I	1a. INSURED'S I.O. NUMBER (For Program in Item 1)
Medicare #) (Medicald #) (Sponsor's 85N) (Member)		
Z. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Lest Name, First Name, Middle Initial)
PLUCKER DEBBIE L 5, PATIENT'S ADDRESS (No., Street)	6, PATIENT RELATIONSHIP TO INSURED	SAME 7. INSURED'S ADDRESS (No.: Street)
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57053 ()	Employed Full-Time Part-Time Student	()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10, 15 PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
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	YES XNO	MM DO TY M F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	B. EMPLOYER'S NAME OR SCHOOL NAME
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d. Insurance Plan name or Program name	10d, RESERVED FOR LOCAL USE	[[] []
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12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this clutin, I also request payment of government benefits either.	release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
balow.	to misen of to me bould who access seeilbrusuf	services described below.
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2		22. MEDIDAID RESUBMISSION ORIGINAL REF. NO.
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Robin Lanpher DC	SYCAMORE AVE Falls SD 57110	506 N Sycamore Ave
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57053	Employed Student Student	14 AND HOLDE BOLLON GROUP OF SECA MUNICIPA	_
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727	
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	7	YES XIO If yes, return to and complete item 9 a	ા-ત.
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 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process this ciaim. I size request payment of government benefits eith 	he release of any medical or other information necessary ner to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplik services described below.	ir for
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nation Langhold no //	N SYCAMORE AVE	506 N Sycamore Ave	
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HEALTH INSURANCE CLAIM FORM	PO BOX 739	DS IA 524073909	SABRER
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5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10, IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR F	ECA NUMBER
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READ BACK OF FORM BEFORE COMPLETON	g & signing this form.	13. INSURED'S OR AUTHORIZED PER	SON'S SIGNATURE I suthorize
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31 SIGNATURE OF PAYERSAN CONTRIBUTION OF SERVICE STREET		\$ 52 00 \$	00 5 52 00
ARCLUDING NEDBERS OF CHOENTIALS	AGILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH I	(609 334 8073
apply to this bill and are spadd a part thereof.) 506 N	NPHER DC SYCAMORE AVE	Lanpher Chiropr 506 N Sycamore	AVE
10/18/2011	Falls SD 57110	Sioux Falls SI	571105737
SIGNED DATE 140783	4419	*1407834419	
NUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938	-0999 FOFM CMS 3500 (08/08

10/24/2011 12:17 PM

	UNITED FIR	RE CASUALTY
1500)	PO BOX 739	009
HEALTH INSURANCE CLAIM FORM	CEDAR RAPI	DS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		PIOA ITTI
	A GROUP EEGA OTHER	1a. INSURED'S LO. NUMBER (For Program in liem 1)
1. MEDICARE MEDICAID TRICARE CHAMPUS (Medicare #) (Medicaid #) (Sponzor's SSN) (Member:	A GROUP HEALTH PLAN FECUNIS (ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle Intial)	a LOTheist Ministration and	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PLUCKER DEBBIE L 5. PATIENT'S ADDRESS (No., Sires)	8, PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
45730 SD HWY 44	Self X Spouse Child Other	SAME
CITY STATE	- I have been been been been been been been be	NEW CONTRACTOR OF THE PARTY OF
PARKER SD	Single Married Other	
ZIP CODE TELEPHONE (Include Area Code)	Full-Time Part-Time	ZIP CODE TELEPHONE (Include Area Code)
57053 () 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Employed Student Student 10, IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POUCY GROUP OR FECA NUMBER
9 (4.3 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 - 1.4 -	Control of the Contro	ZIP CODE TELEPHONE (Include Area Code) () 11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727 e. INSURED'S DATE OF BIRTH MM DD YY D. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME UNITED FIRE AND CASUALTY d. IS THERE ANOTHER HEALTH BENEFIT PLANY
S. OTHER INSURED'S POUCY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
NOTHER INSTRUCTS DATE OF RIGHT	b. AUTO ACCIDENTY	M F
b. OTHER INSURED'S DATE OF BIRTH SEX	X YES NO SD	b. EMPLOYER'S NAME OR SCHOOL NAME
G. EMPLOYER'S NAME OR SCHOOL NAME	COTHER ACCIDENTY	C. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	UNITED FIRE AND CASUALTY
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	
DEAD GARM OF PODE DETORE COURT ETTE	C L COUNTY TOPS	YES X NO If yes, rotum to and complete item 9 s-d,
READ BACK OF FORM BEFORE COMPLETIN 12. PAYIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits eithe	release of any medical prother information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical baselfis to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE	to rive at to the hard and accepts another than	SIGNATURE ON FILE
SIGNED STATESTAL ON TELE	DATE	SIGNED
14. DATE OF CURRENT) 05M 24D 2011 (ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD 1 YY	FROM TO PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17		18. HOSPITALIZATION DATES HELATED TO CUPRENT SERVICES
19, RESERVED FOR LOCAL USE		20. OUTSIDE LAB? S CHARGES
05 25 2011		YES NO
21, DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Hors 1, 2		22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
1. [8470	8471	23. PRIOR AUTHORIZATION NUMBER
2 [7231	. _L 72885	
24. A. DATE(S) OF SERVICE B. C. D. PROC	EDURES, SERVICES, OR SUPPLIES aln Unusual Circumstances) DIAGNOSIS	F. G. H. I. J.
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Patricia Science	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 28. AMOUNT PAID 30. BALANCE DUE
31 SIGNATURE OF PHYSICIAN OF SUPPLIES 32 SERVICES	X YES NO	* 52 00 s 00 s 52 00
INCLUDING/DEGREEN/OR/PREDENTIALS	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (609 334 8073
appet out sold and of Ade a profitered in SOS N	NPHER DC SYCAMORE AVE	Lanpher Chiropractic Office 506 N Sycamore Ave
Robin Lampher OC J 506 N Sioux	Falls SD 57110	Sioux Falls SD 571105737
SIGNED DATE 140783		*1407834419 h
NUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FORM CMS-1500 (08/05

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(1600)	UNITED FIR	E CASUALTY
1500)	PO BOX 739	09
HEALTH INSURANCE CLAIM FORM	CEDAR RAPI	DS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		,
1. NEDICARE MEDIDAID TRICARE CHAMPY	A GROWN GUCA CITACIO	1a. (NBURED'S I.D. NUMBER (For Program in Item 1)
1. MEDICARE MEDIDAID TRICARE CHAMPV [Medicare #] [Medicaid #] [Sponsor's SSN] [Member #]	POST HEALTH PLAN POST BLK LUNG COM	1a. INSURED'S I.D. NUMBER (For Program in Hern 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	S. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
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5. PATIENT'S ADDRESS (No., Bireet)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
45730 SD HWY 44	Self X Spouse Child Other	SAME
CITY	8. PATIENT STATUS	CITY STATE
PARKER SD	Single Married Other	THE SAME
ZIP CODE TELEPHONE (Include Area Code)	Full-Time [] Part-Time []	ZIP CODE TELEPHONE (Include Area Code)
57053 () () 9, OTHER (NSURED'S NAME (Last Name, First Name, Middle (Athal)	Employed Student Student 10, IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
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& OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a, INSUREO'S DATE OF BIRTH SEX
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b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	D. EMPLOYER'S NAME OR SCHOOL NAME
M F	X YES NO SD	
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/	YES X NO	UNITED FIRE AND CASUALTY
d. Insurance Plan Name or Program Name	10d RESERVED FOR LOCAL USE	1 (-1
READ SACK OF FORM BEFORE COMPLETIN	E SIGNIMA THIS EARLY	YES X NO If yes, return to and complete item 9 a-d. 13, INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE authorize the to process this claim. I also request payment of government benefits either 	release of any medical or other information necessary	payment of medical benefits to the undersigned physician or supplier for sandee described below.
below. SIGNATURE ON FILE	to unless on to see him 4 with contains configurational	SIGNATURE ON FILE
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	GIVE FIRST DATE MM DD YY	FROM TO
17, NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19, RESERVED FOR LOCAL USE), NPI	FROM TO 20, OUTSIDE LAB? S CHARGES
05 25 2011		
21, DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Relate lians 1, 2	3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION
, 8470	8471	CODE ORIGINAL REF, NO.
3		23. PRIOR AUTHORIZATION NUMBER
2 7231	72885	
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25. FEDERAL TAX I.D. NUMBER SSN EIN 25. PATIENT'S 171653	Got Boat Column 96 9 Deco	29. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 5 52 QC
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SIGNED DATE 140783		■1407834419 L
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HEALTH INSURANCE CLAIM FORM		IDS IA 524073909	CARRIE
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		200 IN 324073303	Ş
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1. MEDICARE MEDICAID TRICARE CHAMPUS	- BEALTH PLAN - BIKILING -	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
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PLUCKER DEBBIE L	F X	SAME	e, mode many
5. PATIENT'S ADDRESS (No., Street)	6, PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
45730 SD HWY 44	Self X Spouse Child Other	SAME	[]
CITY STATE	8. PATIENT STATUS	СПУ	STATE
PARKER SD	Single Married Other		
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9. OTHER INSURED'S NAME (Last Name, First Name, Middle (nibal)	Employed Student Student 10, IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA	NIMARED P
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& OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (Ourrent or Previous)	a. INSURED'S DATE OF BIRTH	SEX E
<u> </u>	YES XNO	MM DD Y YY	M F Z
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENTY PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	
M F	XYES NO SD		
C. EMPLOYER'S NAME OR SCHOOL NAME	G. OTHER ACCIDENTY	c. INBURANCE PLAN NAME OR PROGRAM	160
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES X NO	UNITED FIRE AND d. 15 THERE ANOTHER HEALTH BENEFIT	CASUALTY
a. Modernot , carraine of the Hodinan long	100. RESERVED FOR ECONE DOS		m to and complate item 9 a-d,
READ BACK OF FORM BEFORE COMPLETIN 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURIE 1 authorize the	G & SIGNING THIS FORM.	13. INBURED'S OR AUTHORIZED PERSON	'S SIGNATURE authorize
to process this chain. I also request payment of government benefits either	release of any medical or other information necessary to myself or to the party who accepts assignment	payment of medical benefits to the under services described below.	signed physician or supplier for
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177			TO MM DO YY
19. RESERVED FOR LOCAL USE			\$ CHARGES
05 25 2011		YES NO	4
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Rolate Items 1, 2 8470	EL HEROZYOTA DIGITZ MEGSENI ANI DADIHAN	22. MEDICAID RESUBMISSION ORIGINA	L REF. NO.
1	8471 Y	23. PRIOR AUTHORIZATION NUMBER	
7231	7241	20. PHON ACTION EXTRON NUMBER	
24. A. DATE(S) OF SERVICE B. C. D. PROCE	EDUAES, SERVICES, OR SUPPLIES E.	F. G. H. I	<u> </u>
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25. FEDERAL TAX LD. NUMBER SSN EIN 26, PATIENTS	ACCOUNT NO. 127 ACCOUNT ACCOUNT		
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3 DEIGNATURE OF STYLCTON OF SUPPLIER 32 SERVICE F	ACILITY LOCATION INFORMATION	\$ 52 100 s 33. BILLING PROVIDER INFO & PH # (1001 52 00
VYCLUDING USARRUS PIZZEREDEN VALS 1	PHER DC	To the second se	605) 334 8073
Robin Langher OC 506 N	YCAMORE AVE	Lanpher Chiroprac	tic Office
10711/2011 STOUX F	alls SD 57110	506 N Sycamore Av Sioux Falls SD 5	71105737
SIGNED DATE 1407834	1419	1407834419	
NUCC Instruction Manual available at: www.nucc.org			99 F URIO (00 (78 (500 (08/05)

09/30/2011 10:00 AM

1500	UNITED FI PO BOX 73	RE CASUALTY	
HEALTH INSURANCE CLAIM FORM		IDS IA 524073909	50 BX
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	albrit 104	200 2A 32 V 33V3	
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I, MEDICARE MEDICAID TRICARE CHAMPU	HEALTH PLAN PLK II ING	1& INSURED'S I.D. NUMBER	(For Program in Itam 1)
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2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATTENT'S BIRTH DATE SEX	4. INSURED'S NAME (Lest Name, First Na	me, Middle Initial)
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45730 SD HWY 44	B. PATIENT STATUS	СПУ	STATE
PARKER SD	Single Married Other	•	017.1.
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPH	IONE (Include Area Code)
57053 ()	Employed Full-Time Part-Time Student Student	1 ()
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. 16 PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR PEC	A NUMBER
	1	4001032727	
B. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	A INSURED'S DATE OF BIRTH	STATE HONE (include Area Code) A NUMBER SEX M F M ME MANAME D CASUALTY IT PLAN?
	YES NO		M F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENTY PLACE (State)	b, EMPLOYER'S NAME OR SCHOOL NAME	AE.
M F	XesNoSD		
g. Employer's name of school name	c. OTHER ACCIDENTY	C. INSURANCE PLAN NAME OR PROGR.	
d, INSURANCE PLAN NAME OR PROGRAM NAME	YES XNO	UNITED FIRE AN	41 11 11/1-11
O, INSUITATIVE PERFECTION TO THE TANKE	10d. RESERVED FOR LOCAL USE		
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 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE authorize the to process this club. I also request payment of government banafits either 	release of any medical or other information necessary	payment of medical benglits to the und	
below. SIGNATURE ON FILE	to this are and head some mediument		E ON FILE
SIGNED	DATE	SIGNED	- ON 1422
14. DATE OF CURRENT: ILLNESS (First symptom) OF 15.	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	18. DATES PATIENT UNABLE TO WORK	IN CURRENT OCCUPATION
O J Z T Z D Z T Y PREGNANCY (LMP)	GIVE FIRST DATE MM DD YY	FROM	TO TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED	TO CURRENT SERVICES
19, RESERVED FOR LOCAL USE	b. NPI	FROM	то
05 25 2011		20. OUTSIDE LAB?	S CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY (Relate liems 1, 2	3 pc 4 to them 24F by (ine)	YES NO	
. 8470	. 8471	22. MEDICAID RESUBMISSION ORIGIN	AL REF. NO.
1		23. PRIOR AUTHORIZATION NUMBER	
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24. A. DATE(S) OF SERVICE B. C. D. PROC	EDURES, SERVICES, OR SUPPLIES E.	F. G. H.	f. J.
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	ACCOUNT NO. 27. ACCEPT ASSIGNMENTY	28. TOTAL CHARGE 29. AMOUN	
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	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #	7 605 334 8073
ROB L	ANPHER DC	Lanpher Chiropr	actic Office
Robin Lanpher DC (1000)	SYCAMORE AVE	506 N Sycamore	Ave
09/27/2011 310ux	Falls SD 57110		571105737
SIGNED DATE a. 14078	34419 a ;	a 1407834419a	One in the latest the
IUCC Instruction Manual available at; www.nucc.org		ADDROVED OMP 2002 A	OOD ECHRONICA CONTROL (OO)

09/30/2011 10:00 AM

Rob Lanpher, D.C.

506 N. Sycamore Ave. Sioux Falls, SD 57110

MasterCard	VIS3	Discover	American Express
Card Number			Amount
Signature			Expiration Date

Amount Enclosed: ________Account Number: 7780

Debble L. Plucker 45730 SD HWY 44 Parker, SD 57053

		Module			And an accordance			TO BE SEED OF THE SEED OF		07555880151.		
Reference		count		Patient	Incident		Last Paymer	it Date		yment Am	punt	
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Date	Patlent	Ins, Bill Date	Dr	CPT.	Description	EOBij	Charges	Pending (Insurance Payments	Patient'	Discount	Patient Balance
05/25/11	P1	06/01/11	D1	99214-25	Office/outpatient visit; est; 25 m	- IFANALA III.	130.00	0.00				130.0
05/25/11	P1	06/01/11	D1	97035	Ultrasound therapy	***	25.00	0,00	-			25.0
05/25/11	P1	06/01/11	D1	98940	Chiropractic manipulation; spina		52,00	0.00				52.0
05/25/11	P1	06/01/11	D1	72040-22	X-ray exam of neck spine; cervic		80.00	0.00				80.0
05/25/11		06/01/11	D1	97032	Electrical stimulation		25.00	0.00				25.0
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09/12/11		09/19/11		98940	Chiropractic manipulation; spina,		52,00					52.0
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09/12/11			D1	97032	Electrical stimulation		25.00					25.0
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09/21/11		09/23/11			Chiropractic manipulation; spina		52.00		and Aller and Al		 	52.0
Doctor Le	// C	1-17-1-7	10	1505.11	and approved the inputation of abutton.		J	0.00	4	L	<u> </u>	52.0
D1 Rob	R. Lanph		co e	hiropractor		Suran at	0					
Patient an Debbie L						Current	Over		Over 60		ver 90	Balan
VVA	-ideket (110U)			Patient Portion: Insurance Portion:	324.00	265	.00	180.00		0.00	1,465.0

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[1500]		RE CASUALTY 监
HEALTH INSURANCE CLAIM FORM	PO BOX 73 CEDAR RAF	3909 PIDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		8
PICA		PICA TTT
1. MEDICARE MEDICAID TRICARE CHAMPUS (Medicare #) (Medicaid #) (Sponsor's SN) (Member #)	HEALTH PLAN BUCLUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	S. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Lost Name, First Name, Middle Initial)
PLUCKER DEBBIE L		SAME
S. PATIENT'S ADDRESS (No., Street)	8. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
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57053 ()	Employed Student Student	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727
B. OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (Current or Previous)	s. INSURED'S DATE OF BIRTH SEX
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b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENTY PLACE (State)	ZIP CODE TELEPHONE (Include Area Code) TIT. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727 B. INSURED'S DATE OF BIRTH MM DD M F D. EMPLOYER'S NAME OR BCHOOL NAME C. INSURANCE PLAN NAME OR PROGRAM NAME UNITED FIRE AND CASUALTY d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
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d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d, IS THERE ANOTHER HEALTH BENEFIT PLAN?
DEAD RACK OF ROOM BEFORE COMMISTRE	d - Sichino This rope	YES NO If yes, return to and complete item 8 a.d.
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17.	8.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
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19, RESERVED FOR LOCAL USE 05 25 2011		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Relate Items 1, 2	, 3 or 4 to Hern 24E by Une)	22. MEDICATO RESUBMISSION ORIGINAL REF. NO.
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apply to the bill and sta to the a not the real.	ANPHER DC	Langher Chiropractic Office
Robin Lanpher oc 506 N	SYCAMORE AVE Falls SD 57110	506 N Sycamore Ave
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09/21/2011 09:22 AM

	UNITED FI	RE CASUALTY
1500	PO BOX 73	1909
HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM GLAIM COMMITTEE 08/03		909 PIDS IA 524073909
TTPICA		PICA [TT]
1. MEDIGARE MEDICAID TRICARE CHAMPV	HEALTH DIAN PURLING	1st. INSURED'S I.D. NUMBER (For Program in Item 1)
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2 PATIENT'S NAME (Last Name, First Nume, Middle Intilat) PLUCKER DEBBIE L	3 PATIENT S BINIH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME
6. PATIENT'S ADDRESS (No., Sirvel)	6, PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
45730 SD HWY 44	Self X Spouse Child Other	SAME
CITY	8. PATIENT STATUS	OTTY STATE
PARKER SD ZIP CODE TELEPHONE (Include Area Code)	Single Married Other	ZIP CODE TELEPHONE (Include Area Code)
57053 ()	Employed Student Student	[()
9. OTHER INSUREO'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	ZIP CODE TÉLEPHONE (Include Area Code) () 11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727 a. INSURED'S DATE OF BIRTH SEX b. EMPLOYER'S NAME OR SCHOOL NAME C. INSURANCE PLAN NAME OR PROGRAM NAME UNITED FIRE AND CASUALTY d. IS THERE ANOTHER HEALTH BENEFIT PLANY
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E EMPLOYER'S NAME OR SCHOOL NAME	o, OTHER ACCIDENTY	C. INSURANCE PLAN NAME OR PROGRAM NAME
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0, INSUPANCE PLAN NAME ON PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH GENEFIT PLAN? YES 340 #yes, return to and complete item 9 a-d.
READ BACK OF PORM BEFORE COMPLETING	G & SIGNING THIS FORM,	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I sushoulde the to process this claim. I also request payment of government benefits either	to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE		SIGNATURE ON FILE
SIGNED 14. DATE OF CURRENT: #ILLNESS (First symptom) OR 15.	IF PATIENT HAS HAD SAME OR SIMILAR ILL NESS	SIGNED
14. DATE OF GURRENT: ALLNESS (First symptom) OR 15. 05 24 2011 PREGNANCY(LMP)	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. CIVE FIRST DATE MM DD 1	18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM DD TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17/		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
19. RESERVED FOR LOCAL USE	o. NPI	FROM TO 20. OUTSIDE LABY S CHARGES
05 25 2011		YES NO !
21, DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Rems 1, 2,		22, MEDICAID RESUBMISSION ORIGINAL REF, NO.
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24. A. DATE(S) OF SERVICE B. C. D. PROCE	DURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.
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25. FEDERAL TAX LO. NUMBER SSN EIN 26. PATIENT'S	ACCOUNT NO. 27. ACCEPT ASSIGNMENTY	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
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T STIPS NI	PATERMENT DATE	506 N Sycamore Ave
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HEALTH INSURANCE CLAIM FORM	PO BOX 7	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	CEDAR RAI	PIDS IA 524073909
TTPICA		PICA TTT
1. MEDICARE MEDICAID TRICARE CHAMPU	A GROUP FECA OTHER ON) (SSN o'10) (SSN) (SSN)	1a. INSURED'S LD. NUMBER (For Program in Item 1)
(Maclicare #) (Medicald #) (Sponsor's SSN) (Member)	Local Local Local	
2. PATIENT'S NAME (Last Name, First Name, Middle trillis)	3. PATIENT'S BIRTH DATE SEX	4, INSURED'S NAME (Last Name, First Name, Mickile Initial)
PLUCKER DEBBIE L 5. FATIENT'S ADDRESS (No., Sireel)	6. PATIENT RELATIONSHIP TO INSURED	SAME 7. INSURED'S ADDRESS (No., Street)
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PARKER SI		
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)
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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	ZIP CODE TELEPHONE (Include Area Code) () 11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727 a. INSURED'S DATE OF BIRTH SEX M DO M F b. EMPLOYER'S NAME OR SCHOOL NAME C. INSURANCE PLAN NAME OR PROGRAM NAME UNITED FIRE AND CASUALTY d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
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a, OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY SEX
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C. EMPLOYER'S NAME OR SCHOOL NAME	a. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
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READ BACK OF FORM BEFORE COMPLETIN 12, PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I authorize the	ralesse of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either below.	to myself or to the party who accepts assignment	services described below.
SIGNATURE ON FILE	DATE	SIGNATURE ON FILE
		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
14. DATE OF CURRENT: ILLNESS (First symptom) OR 15. 15. 15. 15. 16	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	FROM MM DD YY
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09/05/2011 Sioux	Falls SD 57110	Sioux Falls SD 571105737
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NUCC Instruction Manual available at: www.nucc.org	The state of the s	APPROVED OMB-0938-0999 FORM CMS-1500 (08/05

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HEALTH INSURANCE CLAIM FORM		3909 PIDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		The second secon
1. MEDICARE MEDICAID TRICARE CHAMPA	/A GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
1. MEDICARE MEDICAID TRICARE CHAMPUS (Medicare #) (Medicare #) (Sporcar's SSN) (Member)	HEALTH PLAN BUX LUNG	, , , , , , , , , , , , , , , , , , , ,
2. PATIENT'S NAME (Last Name, First Name, Middle (nital)	S. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Inhial)
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B. OTHER INSURED'S POLICY OR GROUP NUMBER	a_EMPLOYMENT? (Current or Previous)	a. INSURBO'S DATE OF BIRTH SEX
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	1	YES XO Hyes, return to and complete item B a-d.
READ BACK OF FORM BEFORE COMPLETIN 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the	G & SIGNING THIS FORM. release of any medical or other information necessary	19, INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I suihorize payment of medical benefits to the undereigned physician or supplier for
to process this dalm, I also request payment of government benefits either below.	r to myself or to the party who accepts exsignment	- services described below.
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	iain Unusual Circumstances) DIAGNOSIS	S CHARGES
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08/24/2011 Sioux	Falls SD 57110	506 N Sycamore Ave Sioux Falls SD 571105737
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NUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FORM CMS:1500 (08/05)

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1500	UNITED F PO BOX 7	IRE CASUALTY	g
HEALTH INSURANCE CLAIM FORM		PIDS IA 524073909	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		54	PIOA ITTTI
1. MEDICARE MEDICAID TRICARE CHAMPY	A GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER	(Por Program in Item 1)
1. MEDICARE MEDICAID TRICARE CHAMPUS (Medicare II) (Medicaid II) (Sponsor's SSN) (Member II)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PLUCKER DEBBIE L	3. PATIENT'S BIRTH CIATE SEX	4. INSURED'S NAME (Last Name, First I SAME	lame, Middle Initial)
5, PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
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ZIP CODE TELEPHONE (Include Area Code)	1	ZIP CODE TELE	PHONE (Include Area Code)
57053 ()	Employed Student Student Student	()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10, IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FE 4001032727	PHONE (Include Area Code)) ICA NUMBER SEX M F AME RAM NAME AND CASUALTY FIT PLAN?
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Gurrent or Frevious)	a. INSURED'S DATE OF BIRTH	SEX
b. OTHER INSURED'S DATE OF BIRTH	b, AUTO ACCIDENT?	19000	M F
b. OTHER INSURED'S DATE OF BIRTH SEX	PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL N	AME
O. EMPLOYER'S NAME OR SCHOOL NAME	O. OTHER ACCIDENT?	G. INSURANCE PLAN NAME OR PROG	RAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES X100	UNITED FIRE A d. IS THERE ANOTHER HEALTH BENE	AND CASUALTY
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to process this claim. I also request payment of government benefits either below.	to mysell or to the party who accepts assignment	services described below.	socially less buly alcost its authorism (its
SIGNATURE ON FILE	DATE	SIGNAT	URE ON FILE
14. OATE OF CURRENT: ILLNESS (First symptom) OR 15. O5 24 2011 PIXER (Accident) OR 15.	IF PATIENT HAS HAD SAME OR SIMILAR LLNESS.	16. DATES PATIENT UNABLE TO WOR	RK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17.		18. HOSPITALIZATION DATES RELATION	TO ED TO CURRENT SERVICES
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19. RESERVED FOR LOCAL USE 05 25 2011		20, OUTSIDE LAB?	\$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate liems 1, 2	, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION	IINAL REF. NO.
1. 8470	. <u>8471</u>	5100	
2 7231	. 7241	23. PRIOR AUTHORIZATION NUMBER	M
24. A. DATE(S) OF SERVICE B. C. D. PROC	EDURES, SERVICES, OR SUPPLIES E. alln Unusual Circumstances) DIAGNOSIS	F. G. H.	I. J.
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25. FEDERAL TAX I.D. NUMBER SSN EIN 28. PATIENT'S	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29, AMC	NPI SO. BALANCE DUE
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Bohin Lapphor ## // JUO N	SYCAMORE AVE Ealls SD 57110	506 N Sycamore	AVE 5D_521105737
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NUCC Instruction Manual available at: www.nuco.org		APPROVED OMB-0938	-0899 FORM CMS 1500 (08/05

08/17/2011 09:10 AM

[1500]	UNITED FI PO BOX 73	
HEALTH INSURANCE CLAIM FORM		IDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	CEDAR TOTAL	100 IN 324013303
TTPICA		PICA [TT
1. MEDICARE MEDICAID TRICARE CHAMPV.	A SHOUP PLAN FECA OTHER PLANT (SSN or ID) (SSN) (70)	1a_ INSURED'S 1.D. NUMBER (For Program in item 1)
(Medicare #) (Medicald #) (Sponsor's SSN) (Member it	(10) (SSN or 10) (SSN) X (10)	
2. PATIENT'S NAME (Last Name, First Name, Middle Inhial)	3. PATIENT'S BIFTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PLUCKER DEBBIE L	, , , , , , , , , , , , , , , , , , ,	SAME
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
45730 SD HWY 44	Sell X Spouse Child Other	SAME
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57053 ()	Employed Full-Time Part-Time	
9, OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
WI 1110 C		4001032727
& OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
D. OTHER INSURED'S DATE OF BIRTH BEX	YEB XNO	_0 N4 4 M 366.12 384
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	TYES IXINO	UNITED FIRE AND CASUALTY
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
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to process this claim. I also request payment of government benefits either	to myself or to the party who accepts essignment	payment of medical benefits to the undersigned physician or supplier for services described below.
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171		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES AMM OD TO
19. RESERVED FOR LOCAL USE	10.1	20. OUTSIDE LAB? S CHARGES
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25. FEDERAL TAX I.D. NUMBER SSN EIN 26, PATIENT'S	ACCOUNT NO. 27 ACCEPT ASSIGNMENTS	28, TOTAL CHARGE 29, AMOUNT PAID 30, BALANCE DUE
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31, SIGNATURE OF PHYSICIAN OR SUPPLIER 32, SERVICE FA	CILITY LOCATION INFORMATION	\$ 60 00's 00's 60' 0
(I confly that the statements on the reverse ROR 1 A	NPHER DC	(00% 354 007 5
apply to this bill and are made a part thereof.)	SYCAMORE AVE	Lanpher Chiropractic Office 506 N Sycamore Ave
Robin Lanpher DC 08/05/2011 Sioux	Falls SD 57110	Sioux Falls SD 571105737
SIGNED DATE #140783		-1407834419 \[\]
NUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FORMA CANSOTE OD (08/0

08/03/2011 08:30 AM

(4700)	INTER ET	RE CASUALTY
[1500]	UNITED FI PO BOX 73	909 ·
HEALTH INSURANCE CLAIM FORM	CEDAR RAP	909 IDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		PICA CTT
1. MEDICARE MEDICAID TRICARE CHAPUS	PVA GROUP FECA OTHER	t 1s. INSURED'S LD, NUMBER (For Program in Item 1)
(Medicare #) (Medicald #) (Sponsor's SSN) (Idem	WION) (SSN OF ID) (SSN) (ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, Flist Name, Middle Initial)
PLUCKER DEBBIE L 5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	SAME 7. INSURED'S ADDRESS (No., Street)
45730 SD_HWY_44	Self X Spouse Child Other	SAME
CITY STA		prove
PARKER S	Single Married Other	
ZIP CODE TELEPHONE (Include Area Code)	Full-Time [Part-Time [Part-T	TELEPHONE (Include Area Code) () 11. INSURED'S POLICY GROUP OR PECA NUMBER 4001032727 e. INSURED'S DATE OF BIRTH MM DD YY M F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME UNITED FIRE AND CASUALTY d. IS THERE ANOTHER HEALTH BENERIT PLAN?
5.70.5.3 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Employed Student Student 10, IS PATIENT'S CONDITION RELATED TO:	11 INCUDENCE POLICY CEPOLE OF SECTION PROPERTY.
S. S. I. L. H. A. S. L. S. C.	W, IS PATES TO CONDITION REDATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727
& OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
	YES X NO	MM DD YY M F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENTY PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	C. OTHER ACCIDENT?	a Mariasakar Bi Ahi Mayar an areasa
	YES XNO	UNITED FIRE AND CASUALTY
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d, RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO // yes, return to and complete item 9 s.d.
READ BACK OF FORM BEFORE COMPLE 12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I authorize	ING & SIGNING THIS FORM. the release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits at below.	her to myself or to the party Who accepts assignment	PRINCES DESCRIBED DEION,
SIGNATURE ON FILE	DATE	SIGNATURE ON FILE
14. DATE OF CURRENT: ILLNESS (First symptom) OR O5 24	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	
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17. HAME OF REFERRING PROVIDER OF CIMER SOUNCE	17a NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE	1. Complete	FROM TO 20. OUTSIDE LAB? \$ CHARGES
05 25 2011	*	YEB NO
21. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Relate liens	, 2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
1. <u>847.0</u>	3, <u>8471</u>	
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24. A. DATE(S) OF SERVICE B. C. D. PRO	CEDURES, SERVICES, OR SUPPLIES 6.	F. G. H. L.
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	S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN CA SUPPLIER 132 SERVICE	FACILITY LOCATION INFORMATION	s 60 00 s 00s 60 00
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07/25/2011 LSi.QU	_Ealls_SD_57110	506 N Sycamore Ave Sioux Falls SD 571105737
SIGNED DATE 14071	334419	- 1407834419
IUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FARM 62/15/00 (08/05

07/25/2011 09:19 AM

(1500)	UNITED FI PO BOX 73	IRE CASUALTY
HEALTH INSURANCE CLAIM FORM		PIDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	CLDAK KAR	-103 IM 3240/3505
PICA		PICA [T]
1. MEDICARE MEDICAID TRICARE CHAM	HEALTH PLAN BUX LUNG	1 1a. INSURED'S LD. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (Sporsor's SSN) (Memb	(SSN) (SSN or ID) (SSN) (ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PLUCKER DEBBIE L	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	SAME 7. INSUREO'S ADDRESS (No., Street)
45730 SD HWY 44	Self X Spouse Child Other	SAME
CITY	8, PATIENT STATUS	CITY STATE
PARKER S	Olher Other	
ZIP CODE TELEPHONE (Include Area Code) 57053 ()	Full-Time Pert-Time	ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initiat)	10, IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FEQA NUMBER
The state of the s	TOTALLET SOCIETION RECOVED TO	4001032727
L OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIFTH SEX
	YES NO	MM DD YY M F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENTY PLACE (State)	b. EMPLOYERS NAME OR SCHOOL NAME
E EMPLOYER'S NAME OR SCHOOL NAME	a OTHER ACCIDENT?	- INDUDANCE BLANAGO
, this to the drawne of sold of theme	Yes XNO	G, INSURANCE PLAN NAME OR PROGRAM NAME
I. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	UNITED FIRE AND CASUALTY d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO # yes, return to and complete Hern 9 s-d.
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to process this claim. I also request payment of government benefits all below.	er to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier to services described below.
SIGNATURE ON FILE	DATE	SIGNATURE ON FILE
14. DATE OF CURRENT: ILLNESS (First symptom) OF	DATE	SIGNED
05 24 2011 (ILNESS (First symptom) OF INJURY (Accident) OR PREGNANCY(LMP)	5. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16, DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
	76.	18, HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE	7b. NPI	FROM TO
05 25 2011		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1	2, 3 or 4 to Item 24E by Line)	22. CODE ALD REGURMISSION ORIGINAL REF. NO
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., 7231	7999 340	23. PRIOR AUTHORIZATION NUMBER
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	plain Unusual Circumstances) DIAGNOSIS	I OH DANNY THE TELEVISION
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5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT	S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28, TOTAL CHARGE 29, AMOUNT PAID 30, BALANCE DUE
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IL SCHATURE OF PHYSICIA OR STATUER 22. SERVICE IN DINING DURING PHYSICIA OR THE	ANPHER DC	Lanpher Chiropractic Office
Robin Iannhar AC / IOUC N	SYCAMORE AVF	506 N Sycamore Ave
07/15/2011 Sioux	Falls_SD_57110	Sioux_Ealls_SD_571105737 *1407834419 *
UCC Instruction Manual available at: www.nucc.org	34419	
The state of the s		APPROVED OMB-0938-0998 FOR 100009 9500 (08/0

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[1500]		IRE CASUALTY
HEALTH INSURANCE CLAIM FORM	PO BOX 73	3909 PIDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	CEDAR RAP	PIDS IN 324073505
T PICA		PICA [TT]
	- LEATTUBIAN BIKIING -	1a. INSURED'S I.O. NUMBER (For Program in Item 1)
1. MEDICARE MEDICAID TRICARE CHAMP\ (Medicare #) (Medicaid #) (Spansar's SSN) (Member:	(OII) (SSN or ID) (SSN) (SSN)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PLUCKER DEBBIE L	S. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRÉSS (No., Street)
45730 SD HWY 44	Self ASpause Child Other	SAME
PARKER SI		ZIP CODE TELEPHONE (Include Area Code) () 11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727 D. INSURED'S DATE OF BIRTH DD W B. EMPLOYER'S NAME OR SCHOOL NAME UNITED FIRE AND CASUALTY d. ISTHERE ANOTHER HEALTH BENEFIT PLAN?
ZIP CODE TELEPHONE (Include Area Code) 57053	Full-Time Part-Time	ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Employed Student Student 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
& OTHER INSURED'S POLICY OR GROUP NUMBER		4001032727
FOLLER MACKED & LODOL ON BROOK WOMBEH	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
b. OTHER INSURED'S DATE OF BIRTH SEX	h ALITO ACCIDENTE	b. EMPLOYER'S NAME OR SCHOOL NAME
MM DD YY	PLACE (State)	
C. EMPLOYER'S NAME OR SCHOOL NAME	O. OTHER ACCIDENT?	D. INSURANCE PLAN NAME OR PROGRAM NAME
	☐ YES ☐XNO	UNITED FIRE AND CASUALTY
d, INSURANCE PLAN NAME OR PROGRAM NAME	104 RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES YES // Yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETES 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I SUBDRIZED THE	a raiease of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S BIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either below. SIGNATURE ON FILE	or to myself or to the party who eccepts assignment	services described below,
SIGNED	DATE	SIGNATURE ON FILE
	, IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	
14. CATE OF CURRENT: A ILLNESS (First symptom) OR IS ILLNESS (First symptom) OR INJURY (Accident) OR IS INJURY (Accident) OR	GIVE FIRST DATE MM DD YY	FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17	a. NPI	16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE 05 25 2011		20. CUTSIDE LAB? S. CHARGES
21, DIAGNOSIS OF NATURE OF ILLNESS OF INJURY (Relate froms 1, 2		22. MEDICAID RESUBMISSION
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Robin Lanpher DC Present) 506 N	SYCAMORE AVE	506 N Sycamore Ave
07/29/2011 STOUX	Falls SD 57110	STOUX Falls SD 571105737
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NUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0998 FQ F4 6349 600 (08/05

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HEALTH INSURANCE CLAIM FORM		IDS IA 524073909	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		N/	
1. MEDICARE MEDICAID TRICARE CHAMPI			PICA TT
1. MEDICARE MEDICAID TRICARE CHAMPIS (Medicare II) (Medicaid II) (Sponsor's SSN) (Member	HEALTH PLAN BUKUUNG	TAL INBUREO'S I.D. NUMBER	(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	1. PATIENTS BIATH DATE SEX	4. INSURED'S NAME (Lust Name, First Name	Middle Initial)
PLUCKER DEBBIE L	FX	SAME	, onesas manay
5. PATIENT'S ADDRESS (Ng., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Stroot)	· · · · · · · · · · · · · · · · · · ·
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57053	Employed Student Student	1	NE (Include Area Code)
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA	VUMBER
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OT UT MOUNTAIN DAYS OF ONE	YES X NO · :	mm DU YY	MI JOHN
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENTY PLACE (State)	D. EMPLOYER'S NAME OR SCHOOL NAME	-
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CONTROL OF SCHOOL NAME	c. OTHER ACCIDENT?	LINTEED STOR AND	
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7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17			O CURRENT SERVICES
17		18, HOSPITALIZATION DATES RELATED TO	O MY DD YY
P. RESERVED FOR LOCAL USE			CHARGES
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1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Rems 1, 2		22. MEDICAID RESUBMISSION ORIGINAL	REF. NO.
3. L 047.0	8471		
, 7231	7241	23. PRIOR AUTHORIZATION NUMBER	
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	(Por povt. ctainin, san brick)	28. TOTAL CHARGE 29. AMOUNT	
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INCLUDING DEGREES OR CREDENTIALS		33. BILLING PROVIDER INFO & PH # (609 334 8073
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obin Lampher DC 500 N Sioux	Falls SD 57110	506 N Sycamore Ave Sioux Falls SD 5	0 71105727
IGNED DATE 140783		-1407834419 \\	(+T/02/2/
OCC Instruction Manual available at: www.nuco.org		APPROVED OMB.0038.000	

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[1500]	UNITED FI PO BOX 73	· · · · · · · ·	- 6
HEALTH INSURANCE CLAIM FORM		IDS IA 524073909	CARRIER
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		9	T
1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPUS	A GROUP FECA OTHER	18. INSURED'S I.D. NUMBER	PICA TT
(Medicare #) (Medicaid #) (Spansor's SSN) (Mericare	HEALTH PLAN IN ICE I MICE	IS. INSOREO S.I.D. NOMBER	(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name.	, Middle Inital)
PLUCKER_DEBBIE_L 5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7, INSURED'S ADDRESS (No., Street)	
45730_SD_HWY_44	Self X Spouse Child Other		*
CITY STATE	B. PATIENT STATUS	GITY	STATE
PARKER SD ZP CODE TELEPHONE (Include Area Code)	Single Married Other		Į į
	Full-Time Past-Time	ZIP CODE TELEPHON	IE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Employed Student Student 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA N) D
	A PROBLEM ADVANCE WITHOUT PROBLEMEN PROPERTY AND THE	4001032727	SEX
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH	SEX E
b. OTHER INSURED'S DATE OF BIRTH SEX	b, AUTO ACCIDENT?		F S
MM LIB YY	YES NO LSD	b. EMPLOYER'S NAME OR SCHOOL NAME	Q
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06/20/2011Si.o.ux_	Ealls_SD_57110	_Sloux_Falls SD 57	71105737
SIGNED DATE *1407834 IUCC Instruction Manual available at: www.nucc.org	14.19.	* 1407834419 APPROVED OVER 1999 1999	

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[1500]	PO BOX 73	RE CASUALTY
HEALTH INSURANCE CLAIM FORM	CEDAR RAF	3909 PIDS IA 524073909
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		PIOA ETTIL
1. MEDICARE MEDICAID TRICARE CHAMPY		· ·
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C. EMPLOYER'S NAME OR SCHOOL NAME	C. OTHER ACCIDENTS	C. INSURANCE PLAN NAME OR PROGRAM NAME
d, INSURANCE PLAN NAME OR PROGRAM NAME	YES XNO	UNITED FIRE AND CASUALTY d is there another health benefit plan?
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NUCC instruction Manual available at: www.nucc.org		AFPROVED OMB-0938-0999 FORMONS 500 (08/05)

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[1500]	- -	IRE CASUALTY
HEALTH INSURANCE CLAIM FORM	PO BOX 7	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	CEDAR RAI	PIDS IA 524073909
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1. MEDICARE MEDICAID TRICARE CHAMP	VA GROUP PLAN FECA OTHER HEALTH PLAN (SSN) (SSN) (SSN) (SSN)	1 is. INSURED'S LD. NUMBER (For Program in Item 1)
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06/06/2011 11:24 AM

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[1500]	UNITED FI	RE CASUALTY
HEALTH INSURANCE CLAIM FORM	PO BOX 73	
APPROVED BY NATIONAL UNIFORM OLAIM COMMITTEE 09/05	CEDAR RAP	IDS IA 524073909
PICA	waiting for med	auth & then recs - slg
I, MEDICARE MEDICAID TRICARE CHAMPUS	A GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Employed Student Student 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
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READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE authorize the	release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either below.	to myself or to the party who accepts assignment	services described below.
SIGNATURE ON FILE	DATE	SIGNATURE ON FILE
14. DATE OF CURRENT: ILLNESS (First symptom) OR 15.	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
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NUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FORM.CMS-1500 (08/05)



United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lloyds

MAY 25 2011

DEBBIE PLUCKER 45730 SD HIGHWAY 44 PARKER, SD 57053-5624

RE: Claim Number:

4001032727

Policy Number:

90625038

Ins. Driver:

DEBBIE PLUCKER

Date of Loss:

05-24-2011

Claimant:

DEBBIE PLUCKER

Loss Location:

I-29 N AT (MRM 071-63 + .108 HARRISBURG SD

V. 68 (20)

Dear Insured:

We have received notice of your loss of 05-24-2011.

The adjuster assigned to service your claim is:

SHERRI WADE PO BOX 73909 CEDAR RAPIDS, IA 52407-3909

Phone No: 319-399-5758 Branch Fax: 800-863-1703

If you wish to visit with your adjuster and have not yet heard from the person assigned to your claim please feel free to contact him/her at the above number.

If you are unable to contact the adjuster and need immediate assistance, please call the office as shown on this letterhead.

Sincerely,

UNITED FIRE & CASUALTY COMPANY Claims Department

May 26, 2011

Debbie Plucker 45730 SD Highway 44 Parker, SD 57053

> RE: Claim: 4001032727 Loss Date: 5/24/11

Dear Ms. Plucker,

We have reviewed your claim and your policy provides Medical Payments Coverage, which will apply to this accident. Medical Payments Coverage pays for reasonable and necessary medical treatment that is reported to us and incurred within 3 years of this accident. This coverage is subject to the \$5,000.00 limit specified in your policy.

Please know that with this coverage will seek recovery for any expenses we pay from Liberty Mutual. You will need to protect our rights when you are ready to settle.

In order to handle your medical claim, we will need the Medical Authorization and Treatment Provider List forms completed and returned to us. The Medical Authorization will allow us to obtain the bills and records associated with this loss. The Treatment Provider List simply tells us who you are treating with.

Because you are a Medicare recipient, we have also enclosed their Consent to Release Form. This form will allow Medicare to communicate with us so we can monitor your billings.

Lastly, it appears that Liberty Mutual is taking care of the damages to your vehicle. If you find out they are not, you have Collision Coverage available to you subject to a \$500.00 deductible. Please let us know if you need to use this coverage.

Please let us know what questions you have. We can be reached at 800-343-9131 ext 5758.

Thank you. Sincerely,

Sherri Wade, Claims Representative



United Fire & Casualty Company United Life Insurance Company Addison Insurance Company Lafayette Insurance Company United Fire & Indemnity Company United Fire Lloyds American Indemnity Company Texas General Indemnity Company

Medical Provider List

Claim#:

4001032727

Insured/Claimant:

Debbie Plucker

List the name and address of each hospital, clinic, doctor or chiropractor where you received medical treatment:

your eceived medical Treatment.
Medical Providers:
Name
Address
City, State, Zip Code
Phone
Name
Address
City, State, ZIp Code
Phone
Name
Address
City, State, Zip Code
Phone
If more space is required, use a separate page.

UF000109

CLAIM NO.: 4001032727	AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
To:(Physician, Hospital, or other)	
I authorize the above named party to release to of the below named patient. This request is being	United Fire and Casualty Company information from the medical recording made at the request of the individual who signed below.
Patient's Name: Plucker, Debbi Patient's Address: 45730 SD Highway 44 Patient's Birth Date:	
THIS CONSENT TO RELEASE INFORMATION	ON IS LIMITED TO THE FOLLOWING:
Any and all medical records, including recovery (if applicable) from 5/24/11 to	reports involving alcohol, drug abuse, or psychiatric treatment or Present.
Or selected medical records, including a recovery (if applicable) from to	reports involving alcohol, drug abuse, or psychiatric treatment or
Use the checklist below to specify category(s) n	ecessary for copying:
History & Physical Exam Discharge Summary Operative Reports Pathology Reports Consultation X-ray Report Laboratory Outpatient	rts New Physician's
This authorization is valid for 12 months from the photocopy of this authorization will be treated in	ne date of signing. It may be revoked in writing at any time. An the same manner as the original.
I acknowledge that information to be released applicable to mental health, alcohol/drug abus such information as specified above.	may include material that is protected by state and/or federal law se, HIV/AIDS or all of these. My signature authorizes release of all
I acknowledge that information used or disclos United Fire and Casualty Company without for	red pursuant to this authorization may be subject to re-disclosure by urther authorization.
requirements prohibit further disclosure without	cords protected by federal law for alcohol/drug abuse records, by state lated records, federal requirements (42 CFR Part 2) and state ut the specific written consent of the patient, or as otherwise permitted riminal penalties may attach for unauthorized disclosure of S information.
Signature of Patient/Guardian	Relationship to Patient if Signed by Guardian
Date of Signature Reason	Patient Unable to Sign

UF000110

CD4030 (04/032003)

July 13, 2011

Debbie Plucker 45730 SD Highway 44 Parker, SD 57053

> RE: Claim: 4001032727 Loss Date: 5/24/11

Dear Ms. Pluoker,

This letter serves as a friendly reminder that in order to assist you with this claim, you must fulfill the obligations outlined in your policy. Your Personal Auto Policy states:

AGREEMENT

In return for payment of the premium and subject to all the terms of this policy, we agree with you as follows:

PART E - DUTIES AFTER AN ACCIDENT OR LOSS

We have no duty to provide coverage under this policy unless there has been full compliance with the following duties:

- B. A person seeking any coverage must:
- Cooperate with us in the investigation, settlement or defense of any claim or suit.
 Promptly send us copies of any notices or legal papers received in connection with the accident or loss.
 - 3. Submit, as often as we reasonably require:
 - a. To physical exams by physicians we select. We will pay for these exams.
 b. To examination under oath and subscribe the same.
 - 4. Authorize us to obtain:
 - a. Medical reports; andb. Other pertinent records.
 - 5. Submit a proof of loss when required by us.

Currently we have not received the Medical Authorizations we requested and therefore are not able to process your medical claim. We have enclosed these forms again for your completion. Additionally you will find the forms we received from Medicare that are also necessary in order to assist you.

Please let us know what questions you have. We can be reached Monday through Friday from 8:00am until 4:30pm at 800-343-9131 ext 5758.

Thank you. Sincerely,

Sherri Wade, Claims Representative

07/22/2011 09:18 AM



United Fire & Casually Company United Life Insurance Company Addison Insurance Company Lafayette Insurance Company United Fire & Indemnity Company United Fire Lloyds American indemnity Company Texas General indemnity Company

Medical Provider List

Claim#i

4001032727

Insured/Claimant:

Debbie Plucker

List the name and address of each hospital, clinic, doctor or chiropractor where you received medical treatment:

Medical Providers:
Name DR. Kobin Lanpher
Address 506 D. Swamore Avenue
City, State, Zip Code Sioux Falls SD 57110
Phone <u>605-334-8073</u>
Name
Address
City, State, Zip Code
Phone
Name
Address
City, State, Zip Code
Phone

If more space is required, use a separate page.

Maginal is Valid. No copies the Valid. Not Be Signed In 'Red Ink' to be Valid. CLAIM NO .: 4001032727 AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Physician, Hospital, or other) Reviewed slg 07/22/2011 12:44 I authorize the above named party to release to United Fire and Casualty Company information from the medical record of the below named patient. This request is being made at the request of the individual who signed below. Patient's Name: Plucker, Debbie Patient's Address: 45730 SD Highway 44, Parker, SD 57053 Patient's Birth Date: ' Social Security No. THIS CONSENT TO RELEASE INFORMATION IS LIMITED TO THE FOLLOWING: X Any and all medical records from 5/24/11 to Present. Or selected medical records, including reports involving alcohol, drug abuse, or psychiatric treatment or recovery (if applicable) from to Use the checklist below to specify category(s) necessary for copying: History & Physical Exam Consultation Reports Progress Notes Discharge Summary X-ray Reports 🛛 Physician's Operative Reports Nurse's Laboratory Reports Pathology Reports Other (Please specify) Outpatient Information This authorization is valid for a months from the date of signing. It may be revoked in writing at any time.

Reason-Patient Unable to Sign

CD4030 (04/032003)

Signature of Patient/Guardian

06-01-2011 Date of Signature Relationship to Patient if Signed by Guardian